Meaningful Use Workgroup
<mark>Draft Transcript</mark>
May 3, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the Meaningful Use Workgroup. This is a Federal Advisory Committee so there will be opportunity at the end of the call for the public to make comment. Actually, we're meeting in person in the Switzer building in Washington, D.C. Just a reminder for workgroup members to please identify yourselves when speaking. Let's go around the table and introduce members sitting at the table, beginning on my right with Josh Seidman.

Josh Seidman – ONC
Josh Seidman, ONC.

Allen Traylor – ONC – Meaningful Use Policy Analyst
Allen Traylor, ONC.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
George Hripcsak, Columbia.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Paul Tang, Palo Alto Medical Foundation.

Eva Powell – National Partnership for Women & Families – Director IT
Eva Powell, the National Partnership for Women & Families.

Judy Murphy – Aurora Health Care – Vice President of Applications
Judy Murphy, Aurora Health Care.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Charlene Underwood, Siemens.

Judy Sparrow – Office of the National Coordinator – Executive Director
Do we have any members on the telephone, please?

David Lansky – Pacific Business Group on Health – President & CEO
David Lansky.

Judy Sparrow – Office of the National Coordinator – Executive Director
David, good morning. Anyone else? All right, with that I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you very much, Judy. We're probably expecting a couple more members to show up this morning in person and hopefully potentially on the phone. We're here to do a final run through before going to the full committee next week, time flies. Let me – oh you should have teed up our, I'll get it later, our overall work plan. Today we have a couple major objectives. One is to go through the whole thing, so we went through category by category and we left some openings where we tabled some things and had some small groups work out some language and we did leave some questions open that we can discuss today. Some of the perspective we're going to take is in the context of other HHS initiatives that have come up since the last time we met face-to-face, importantly, the National Quality Strategy that the secretary

announced in March, and the ACO NPRM. So when we have a decision point let's try to look with that perspective in mind as we make our final decisions.

The second piece, which will happen after lunch, is to take, again, a step back and look at the timing issue. That was the number one concern that was brought forward when we had our RFC from the public, and there were divided opinions. So we'll have to take that into account, as we always do, in terms of balancing how we want to keep the forward momentum and how we want to stretch ourselves as we reach towards the 2015 stage three horizon, yet we don't want to go beyond what's feasible for the majority of the industry and the providers. Then we'll, as always, end with public comments. I think we have one more call right before the meeting on the 11th. I think it's on the 10th, correct, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
That's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So if we have any last minute things that obviously wouldn't make it into our presentation, and as you know we're presenting all of the objectives at the committee meeting on the 11th. So that's going to be a rather lengthy presentation. Any other additions to the agenda? Why don't we start looking at, again, we'll go through category by category and look at some of our open decision points, if all of us could put in front of us the category objectives. One way to do that is the presentation that was distributed, the color coded ones, do you all have that, under category one, improving quality, safety, efficiency and reducing healthcare disparities. The first item was CCLE, where what we did was we went from 60% of medication orders through a computerized provider order entry, we added to that lab and radiology, and we had a small group that put together some language for us to consider and it's in the packet that was distributed .... The very last in the packet is a letter, and it's the page before that. And in brief, unless, George, do you want to go over that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Sure. Basically—

Judy Sparrow – Office of the National Coordinator – Executive Director
George, excuse me. You do have a clicker. You can advance the slide, if you wish.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Oh, I see. Okay. The question was, whereas for medications we have a medication list to use as a denominator, what do you do for laboratory and radiology? So what we did here was we said well, for laboratory since we're doing structured lab entry maybe we can use that as the denominator. So for laboratory it could look just like medications, whereas, radiology we're not forcing the collection of radiology, therefore, maybe we just do a threshold that's equivalent to attestation except that we get the number of orders. So in effect you just have the numerator and not a denominator. I thought the threshold could be one, unless this is a provider who does not do radiology orders and then they would be exempted. The document clarifies that a licensed professional should be defined in such a way that an automated decision support system can have some effect on the order.

Now, during the Policy Committee meeting we talked about whether we really need to go up on every threshold, so that's something that's open for discussion. This one, which is 60% for medication, 60% for lab, and in effect just minimal use for radiology, we could decide to leave it at 30%, but that's the global discussion. So how would you want to do the global discussion? Do you want to do that as we go along? Do you want to talk about the global discussion, which is namely do we need to increase every threshold?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the things we're going to go through in the timing discussion is that question of how to push. So I think we can consider it as we go. In other words, we're at 30%, I think it's 30% right now, correct?

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thirty percent right now. We had suggested going to 60% for medication. The global discussion is once people were at somewhere around 30% there's no reason not to go beyond that. It basically is more painful to be in a hybrid state. So the thought is do we even need to be pushing some of these things once you're past something like 30%? That's something for us to keep in mind. Our bigger question on this one is adding lab and rad. We did have a lot of support both for the 60% and for the lab rad. Some people were saying, well, could you just do one of the two? In general, CPOE has been always one of our prime targets in the whole EHR incentive program, because that's where the system has the most opportunity ... the orders that are being generated. So we've always found this to be one of our driving pieces of functionality.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, just to remind people, I think some of the previous discussion focused on in the hospital side that people might be doing it department by department. So part of the reason for the threshold was not because, yes, you're right once you do it you're going to do it. The question is if you're doing it department by department.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We certainly wouldn't want them to stop. That would be one thing. So, further discussion about the lab and rad? George, and the small group that worked on this, tried to find a couple ways where it would be less burdensome to report how you're implementing lab and rad. The reason you picked a denominator for lab but not rad was because it's structured?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Because lab is being required to be collected into EHR, whereas, radiology is not being required to be collected into EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. But if you're doing meaningful use we know you have lab data.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But we don't know what you have radiology do. Other comments?

Judy Murphy – Aurora Health Care – Vice President of Applications
Just that it's different in the hospital from the clinic and I'm not sure that we want to bifurcate it all on this metric. But in a hospital you can count the number of orders entered as the denominator, and then you can look at the numerator, how many were entered directly by a physician. In the ambulatory setting you don't know what's going out on paper and so again if we wanted to look at them separately, which I'm not sure we do, it would be easier to determine a numerator and denominator I think in the hospital than in the clinic for lab, rad, or medication. The other thing to point out is medications—is it's not 60% of the orders that are entered, it's 60% of the patients who have at least one medication. So it's even lower than 60%, in truth.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We tried to follow a little bit what Tony said, that we were trying to keep it simple, so we keep it the same for medications, and even for lab if we measure it in the same way for each patient there's a lab order, kind of a surrogate entered for each unique patient. We were okay with that because we were trying to keep a parallel process. They're already counting the patients. They have these two orders, and then they would have one radiology order, unless they attest against it. So that was part of the strategy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, anyone else? Why don't you summarize it one more time and then we can just vote on whether we accept.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
For medication, it would remain as it is except that we go from 30% to 60%, that is what Charlene just said, it's 60% of patients who have at least one medication on the medication list need to have a medication order in the time period. Laboratory would be defined analogously, which is 60% of patients who have at least one lab result in the EHR need to have at least one lab order. Then for radiology it would simply be that at least one patient, period, has a radiology order at this point in time just to show that you've done it and turned on the system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, are we ready to vote on that? All in favor? Any opposed? Any abstained? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you have a vote?

David Lansky – Pacific Business Group on Health – President & CEO
I vote ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm sorry. Did you say yes?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, very good. We'll move on. The next one was drug-drug interactions, and our hope when we came out with the RFC was that we would have some kind of reference to an evidence-based drug-drug interaction table or list. The issue is that most of the commonly used medication databases have a very high false positive rate, and that does a couple of things. One, people tend not to, in fact, there have been studies on it, at Partners and elsewhere, that showed a large percent, the overwhelming majority of these kinds of alerts are passed by, and the reason is because of the high false positive rate.
The other thing is that then when you have alerts that you commonly pass up, then it decreases the value of other alerts, and that's the problem we're trying to solve. Unfortunately, there isn't a current list of alerts that have a stronger positive predictive value. There was a RAND study that we heard about, they had a small list of high priority alerts but of course the incidence and prevalence of those kinds of alerts is very small. So even if we implemented that we'd have something like less than one percent of potential alerts going on.

The other thing that they're working on is maybe a list of ones that do have a high false positive rate so that you can turn those off. The balance here is trying to make sure that you don't miss anything and yet if you want to turn something off to have some cover in terms of the standard or practice so there's no liability issue. At this point we don't have that magic list in either of the .... We had talked about potentially using almost the "never" events, but that's such a small number of the total potential drug-drug interaction alerts. Another possibility is to just encourage people to decide locally what is evidence-based. For the larger organizations they may have a committee that does that. For the smaller organizations they may accept the current thresholds that are presented by the medication database centers. Any thoughts on that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

What I have our ending up at our last in-person meeting was leaving it vague for now, for the reasons you just said, dropping the word "evidence," which I have to review. Then define "employee" because that was one of the questions is what do you really mean by "employ" versus "activate," etc.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we meant I think at the time was it was an on/off switch in our stage one because of this problem actually largely. Then we went further to say we want you not only to turn it on and potentially have all the alerts off to saying we actually are using—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that is correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... it in the actual practice. That's what we meant by "employ," and we can clarify that in our recommendations. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I think that the thing that was important here is we wanted to make sure that the systems had a way for providers to enter alerts that were important. I think if we're thinking about both primary care and specialty, there are things that might be very uncommon in my primary care practice, but might be very common and very important in an oncology practice or in a different type of practice. I think the number one most important thing is that the systems have the capability of having providers be able to enter alerts that are contextually important for their specialty and for their practice. We did talk about is there a list that could be used, and even if there was one today the question of who would be responsible for updating it, how would we call out a requirement that that list be used nationally when there's no process for either endorsing it or updating it at this point is an issue.

I think that a good place would be to basically make sure that the systems have the capability and to call out the fact that eligible providers be required to establish some number, let's say three, three drug-drug alerts that are particularly relevant to their practice. Again, are we stuck then with an attestation kind of thing or can somebody actually measure that it's being used, but I think that's what we want. We want the systems to have the capability, and we want the providers to start using that capability in the ways that are most relevant to their practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think I'd agree with the notion that there would be some way for the providers to in some way modify the alerts that are triggered in addition to just the default from the medication ..., so that's one point you raise. I don't know whether introducing an arbitrary number, maybe a better word than "employ" is "in use," and I think that's your point.

Neil Calman – Institute for Family Health – President & Cofounder
The other thing that we talked about was the ability for the systems to be able to integrate third party resources for drug-drug alerts and other things, that there are a number of, I guess, commercially available databases. One of the other system requirements should be—and I know I'm mixing up the certification issues with meaningful use issues, but I think the requirement needs to be that providers should have the ability to select a database that's most suitable to them. And to have the systems be able to import them and be able to use them as part of their electronic health records.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. So I think the key there was "multiple" meaning greater than one. At one point we had looked at the notion of can they actually accommodate all, and that's a bit of a tall order, so multiple meaning greater than one. Other comments on this? I think what we might do, Josh, is make a note as we write this recommendation that we want to push towards having some kind of list of drugs that have a much higher positive predictive value and some of that work was started. Some of that exists, for example, at Partners and are there other ways of maybe pushing, because ONC had a contract with RAND and

maybe that can be pushed further by stage three. But we want to get into a better position hopefully by stage three. Okay, are we ready with that one then?

W
Just one comment, in the use of these multiple drug databases most vendors contract and use a third party database to do their drug-drug interactions. Again, with those comes the capability of setting levels and those types of things, so there's a lot of ...in them, there's a lot of downside too. So I agree with you, we need to continue to push to refine that so that they can become more sensitive, and I think that's the challenge for the industry. To put in multiple drug databases there's a cost factor, because each one you contact for and you've got to pay for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
By multiple meaning being able to accept more than one, ... make a decision. Not—

W
.... I'm sorry.

M
... the vendor shouldn't necessarily have the capability of picking the database that a particular practice uses.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exclusively.

M
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that if their software were to accommodate the organization making a choice amongst more than one, so Judy—

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, I was just going to say they don't do that. They all partner with one because right now they're all so different. I don't think there are too many vendors that can use more than one, do you know?

W
As a system, we build a lot of infrastructure in, in contractual we have to have the updates, so going across multiple is a challenge right now for the industry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Ours does allow more than one, a choice, so that's interesting.

W
Does it? ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
..., yes.

W
Okay, all right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. That actually locks the provider organizations in to a drug database at the time they're making the ....

W

.... I think it's the exception when there's more than one, to be honest, yes.

M
... the industry I don't think we can really—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think we can—

M
... call that out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But then that might mean your second recommendation, your second suggestion was that the provider organizations can change, make some local changes. So every vendor has a threshold that's across this entire database can the organization decide, okay, we do have our list of either ones that we want to only alert on, or ones that we do not or are exclusionary.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, definitely you can locally. Even within any of the databases that I'm familiar with you can set your levels for both pharmacy to get and/or for the physician to get who's actually doing the other entries. It doesn't even have to be the same. So there's a fair amount of functionality.

M
Can they be selective on a specific item by item basis or just in terms of levels?

Judy Murphy – Aurora Health Care – Vice President of Applications
You don't really want to do that—

M
But there are some.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, you can. Yes. Is it the drug level, or the interaction type, excuse me, and/or individual people and individual drugs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That is ... the things that we were concerned about.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the absence of an industry standard list of course that makes it a maintenance problem because every organization would have to go do that. I think our target still is to have a standard of practice kind of list. That is a far better predictor of notable drug-drug interactions.

Judy Murphy – Aurora Health Care – Vice President of Applications
I would comment then that if you would put that in your intent, what you're trying to do, then that will just make people aware when they do the setup to work towards that. I think that would be helpful. The capability is there, but again, it's not always operationalized.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do we want an intent to be accepting more than one drug database?

W

....

M
Is there a standard way in which these drug databases interface with ... systems?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, unfortunately they use different drug identifiers, is one of our problems. But that is something we have to solve, otherwise we won't have interoperability. In some sense driving in that direction, again signal for stage three, seems like you shouldn't be locked in to a drug database vendor based on your Her vendor.

W
Yes, and just a comment. It is a lot of work because we tried to engineer it to be open to any, but there's work that has to, if it's intrinsic already. This is a pretty big work effort to do that, but to put the signal there I think is okay. I'm not sure it can actualize in that time window.

Judy Murphy – Aurora Health Care – Vice President of Applications
Or if you get at the end state ..., so that's a means to the end of having flexibility locally as to what you want to alert to, so maybe that's really the intent rather than focusing on the how that would be achieved.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so would the EHR vendors be able to accommodate a list? So if there were lists provided, either these are the ones I want you to turn on or these are the ones I do not want you to turn on even in the ... it can be done.

W
....

M
Yes. Okay, that's fair. With running the risk of complicating this more, one of the issues that I think is most critical, and I don't know if we've really discussed this, is a way for the systems to identify when the alerts are bypassed, have a mechanism to actually do that. When we're thinking about meaningful use here to understand how that could be reviewed in a quality improvement kind of mechanism within an organization, my understanding from talking to some of my colleagues is that it's very difficult to do. That some of the systems don't actually, you can't say show me a list of all of the people who bypass drug-drug alerts, so that there's no capability for somebody to go back and review those to see whether or not they were just done on the fly or whether there was some rationale for doing that. Is that now a requirement, that the systems be able to report like that? If not, is that something that we should be calling out? Because I think that's actually more important than the ability to use multiple databases, the ability to actually review when providers are bypassing the alerts.

M
I think that's very reasonable. We did do that in decision support, is to have that capability of tracking how it's being used. There was a wonderful study at Utah, where they talked about even after you get a consensus agreement on guideline that out of the gate you have a very low adoption rate, mainly because you've not thought of so many things. But with this kind of feedback, it goes up very quickly, but it never reaches 100%. I think that's an important functionality that should be part of any decision support, drug-drug interactions or otherwise. So that again we should—

M
We should put that out as part of the drug-drug interactions.

M
For stage one or stage three? Discuss it in stage two with the intent of doing it in stage three?

M

I guess so, because it would—

W
Some systems have it; others don't. So I think it's a mix out there right now.

M
So where did we end up?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we want providers to have the ability to modify the drug-drug interaction alerts and that is in addition to the threshold mechanism that's already part of the drug interaction databases. Second, we want to be able to pick up the EHR vendors software to be able to have users enter a reason for why they are passing, they're ignoring or not following the drug-drug interactions.

M
Stage what?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That we're looking for stage three, mainly because it's probably not available uniformly now.

M
So change locally in stage two, override in stage three, and then perhaps use other databases in stage three.

W
... capture that ....

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

M
And be able to report on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Was there one more that we had?

M
Multiple databases.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, which we turned down as a how. Okay, we're making progress. The next one I think we left the same, which is 50% of orders, this is eRx, 50% of orders, that's increased, I believe from 40% and then adding 20% for hospital discharge. The reason it is a lower one is because that's a new functionality.

M
I think that the statement that if it's just a patient preference, I thought we had decided to drop that in favor of lowering the thresholds, because then you have to report on patient preference for everything in order to have a denominator. I thought what we had decided to do is basically maintain a lower threshold so we didn't have to figure out whether every single person—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point.

M
... had a preference or not as part of our lower burden principle.

M
Exactly. So basically if we say at least 50% of patients are going to want their medications prescribed electronically, there's always, I think, a mechanism, isn't there, in the system for somebody for whom a particular requirement is not relevant or impossible to specify that. So that could be an exception thing. But I wouldn't want it to be a denominator that everybody has to report on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If you're saying an exception thing that's automatically reported.

M
It's not. There's not an exception.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Then do we even want to do anything about the numerator, the 40% going to 50%? That's again in keeping with your remarks about once you do this you want to do it with everybody. There's not really an incentive not to ePrescribe.

Judy Murphy – Aurora Health Care – Vice President of Applications
It's sending a message if we go up. Are you proposing, though, that we eliminate the discharge?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

Judy Murphy – Aurora Health Care – Vice President of Applications
Okay. So you're saying 40% and 20%?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I'm saying 50% and 20%, but to take out the part that says "if it fits the patient preference" so that we're not trying to use that as the denominator.

Judy Murphy – Aurora Health Care – Vice President of Applications
Got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And so how are we with the 20%?

M
We're good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, very good. Let me take this moment and remind us, step back and maybe we ought to do this before we go through the rest of these, and that is look at, did everybody review the mapping in the National Quality Strategy and at least the mapping for the ACO NPRM? I suspect most people have not read the whole NPRM. Fortunately, I think, to CMS' credit, for example, that they really thought about this and tried to align these new programs with the existing ones and in particular meaningful use. Certainly in the ACO they piggybacked on a number of the quality measures that are in use for meaningful use, as an example, and I saw nothing that was in conflict at all in the National Quality Strategy with what we're doing in meaningful use. The only addition I might have seen, one is prevention and a lot of these things that would be in the quality measures side really, and a special focus in this first year on cardiovascular disease. We just want to make sure as we go through this, is there anything we could be doing that would support that or advance their initiatives? I certainly didn't see anything in conflict. Did anybody else see anything different? Josh, any special comments in terms of the alignment?

Josh Seidman – ONC
No. Just to reinforce what the goal here was, mostly what you said, I think the National Quality Strategy obviously is the framework and came out of the ACA that really provides a road map for where we hope to go with improving quality in the country. So that's why I put that column first and basically focused on the ten principles. There was an aim and a priority, because the National Quality Strategy has aims, priorities and principles. There was an aim and a priority that didn't seem to be very well captured in the principles in terms of aligning with the specific meaningful use criteria, and one was on affordable care and one was on basically safer care. So I wanted to just call that aim and that priority out, so that was the bottom of that table.

As you say, I think that there is very good alignment among the programs. The only other thing I would just point out I think is we also tried to note where there are certain things that one would need to do, so something that was maybe menu in stage one that would really be expected to be done. Clearly, the ACO provides other levers. There obviously will be other programs coming out which will provide other levers. We also have to be cognizant that not everybody will be doing all of these programs. Obviously the ... program, a voluntary program, may take off. There may be lots and lots of those ACOs in a couple of years and that would mean that the specific things we do in meaningful use wouldn't be as important. On the other hand, it may not cover certain kinds of providers as much, or things like that, and so those are things for the workgroup to consider as well.

I want to give people who walked in since our introductions to announce themselves, and one of them is Farzad. Do you want to just mention that you're here?

Farzad Mostashari – ONC – National Coordinator
Hi, welcome, everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great. Then, Neil and Art?

Neil Calman – Institute for Family Health – President & Cofounder
Neil Calman with the Institute for Family Health.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Art Davidson from Denver Public Health, Denver Health.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thank you.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Paul, just a comment. Thanks. Sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Karen?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Just a follow on to the comments about the ACO and places where meaningful use, where we might be mindful about supporting that. We've got public health criteria but the National Quality Strategy focuses on improving the health of populations, really more so at the community level. Our criteria are very public health oriented and I'm not critical of that, I think that's right, but moving forward we might think some about how can meaningful use support that population perspective at the community level in addition to a very strict public health kind of perspective. I don't have specific ideas about that, but I think it would be useful to be thinking about that, because it seems like the National Quality Strategy really takes that more community perspective as opposed to a strict public health perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that's a fair comment. We did lump them together in category four. I think a lot of the community or population measures would be those that create lists to assess the health of a population or community. So that's a good thing to keep in mind.

Farzad Mostashari – ONC – National Coordinator
Paul, the other mention is that the Affordable Care Act required ... Health and Human Services to create a national quality strategy and a national prevention strategy. So there's also another report, national strategy coming out, that focuses explicitly on the prevention public health strategy, which unfortunately I don't think is out yet. But as soon as that comes I think that's added input to put into the process as well. There's obviously going to be a lot of overlap, as Paul suggested.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think a lot of that will come into the quality measures side, I would guess. One of the things you mentioned, Josh, the emphasis on safety, where we don't have as much called out, I think medication safety probably is one huge opportunity, which is why we just keep coming back to this drug-drug interaction and drug other things interaction. Our difficulty is in this whole false positive kind of problem that we have. So I think, and I know ONC already has contracts on this, but before you came in, Farzad, we were saying to continue to push, certainly by stage three, on having useful lists where we can back down off of these overwhelming false positives in drug-drug interactions.

Josh Seidman – ONC
Useful lists and a mechanism to update them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So it's creating them and maintaining them, and it's not happening in the private sector right now, so one thought is that it might happen in the federal government.

Okay. So we have 50% and 20%. The next one is the stratified quality report, and this has to do with reporting demographics. We had some public comment, so our original plan was to use the ... CDC characteristics for the different demographics, and to move in stage three to the IOM more granular race and ethnicity categories. There was some public comment saying, well, could we move that up even to stage two, and I think that's where part of our question was. This could be a concern that we want to pass over to the HIT Standards Committee and let them rule.

Neil Calman – Institute for Family Health – President & Cofounder
I think the comment I made the last time is that this is one of the areas where calling out doing it right the first time is probably of benefit to the community rather than thinking how we usually think, which is that if we put something off to stage three we give people more time. If you think about the fact that people aren't all collecting things like language, race, and ethnicity now, and people are being registered every day in centers and hospitals across the country that we're going to be asking to report on stuff, it seems to me like we're doing people a favor by saying how we want that done now. We're in the process of moving from our old system to the IOM granular ethnicity, it means re-collecting information on 100,000 people, and every single new registration re-collecting information that we had collected an old way before. I think the earlier we call this out the easier it's going to be on everybody because we have a lot of people implementing EHRs for the first time and they're going to be collecting this data. It's a lot easier for them to collect it once than to say here's how you can collect it in stage two and let the vendors do it that way and then in stage three say, now we want it the IOM way. The vendors have to re-do it and the people have to re-collect all the information.

M
I'm trying to get a sense of where the ... would be.

W
Because there are a lot of entries, to be able to do this, this is a pretty robust development project. Because to even collect it, and you're talking about registration systems, you're impacting the registration systems and there's a lot of them out there, you've got to build it because there's a lot of finesse in the

data capture so it's got to be pretty usable, so it's going to take a while to get that development done. Then there's a cost of the rollout process, because again it changes, every single registration ... has to be educated, changed to the rollout process. I would think you would want to signal this for stage three. I understand you want to do it in stage two, but there's a lot of work to get the infrastructure in place for this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We've been through this, and I would just disagree. What you're doing is you're creating a larger list of selections, but that doesn't require re-programming. To basically say you now have 100 categories to pick from instead of 4 categories doesn't require massive re-programming. Neither does it to get more granular with language and other things. We already collect race, ethnicity and language. The issue is really what categories are used, and that doesn't require a major re-programming effort. Where I agree with you is it does require a provider re-training effort, but that's not a vendor responsibility, that's people within the organization have to teach their registrars and their front desk people how to actually capture that information accurately. What I'm saying is as people are learning and adopting EHRs now, we want them to do that right from the beginning, otherwise they have to re-do it all again in two years, and that doesn't make any sense to me.

M
The only caveat is, are we letting them use ADT feeds or not, which I guess we had said yes last time. The only thing that makes this unusual is now we have to get another vendor to do it, or what we could do is basically not do the ADT feed and just enter the ethnicity data into the EHR separately from the registration process. I think we can change the electronic health records in time, for the reasons you say. But I don't know if we can change the registration systems in time, I don't know if doctors want their workflow to change so that someone has to go into the EHR to enter the ethnicity data separate from— we just asked them the same question and gave them different categories a minute ago in my registration system. Now I'm asking you again and I'm asking you to characterize yourself differently. So that was what the discussion got bogged down with at the last in-person meeting.

M
What's your response to that?

M
There are a number of things that are part of the registration process that weren't two years ago, so we now ask people what their preferred pharmacy is. That's not in the ADT feed, but it is a requirement for electronic prescribing that we know what their preferred pharmacy is. You just said that we also asked about their primary care provider, so there's a number of things that are not fed automatically that are part of the EHR demographic registration process, and I think race and ethnicity could be part of that.

Eva Powell – National Partnership for Women & Families – Director IT
To support Neil's comment, I think the usefulness of the reports that they're going to be stratifying in many places they won't be useful using the small number of categories we're now requiring, in many places they're going to require the larger set. So I'm hesitant to require providers to do something just for the sake of doing it and not have it be useful to them. So I would agree with Neil that going ahead is probably the better way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Based on your last comment, Neil, then you're saying that the provider would actually add to the demographics of an individual by specifying these more granular ethnicity—

Neil Calman – Institute for Family Health – President & Cofounder
It doesn't have to be the provider. What I was basically saying is that there are additional things that go on as part of registration now that aren't all from the traditional registration process and soon we're going to be picking preferred other providers, and we're talking about people designating who's on their healthcare teams. There's a lot of information that we're capturing now, and we capture information on whether their healthcare privacy, whether they have a proxy, whether there are advanced directives in

place in the system. All of those are part of the registration process. I don't think we should specify who has to do it, but I'm saying that there are additional pieces of data that are captured now that are not part of a normal data feed from a registration system and this should be part of it.

M
We would still allow an ADT feed, we're just recognizing that if we put this rule in they may not be able to use it because their ADT is not full enough, but we still allow it if it works. I think a lot of people just map whatever they've got in their ADT systems to an inappropriate category, and the EHR is a likely side effect.

M
But we know that's not complete information and that they're capturing lots of other things in addition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Comments?

M
I'll just make a couple of comments. One is just going back to some of the discussions that I think happened around the timing discussion. Part of the timing discussion relates to what's in the stage, so the questions, certainly valid concerns that Charlene raised about how long it will take to do this reconfiguration might relate to when stage two is implemented. If we keep on the current schedule we might have one set of expectations for this and some other objectives and if we go to a different time of timing of stage two then it might have a different set of expectations. But certainly just getting back to the previous conversation about the National Quality Strategy, certainly this is a very high priority for that. There are some things in the ACO rule calling out about evaluation of population health needs and consideration of diversity, so that certainly is an expectation of I think some of the key delivery systems ... going forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Other comments?

Judy Murphy – Aurora Health Care – Vice President of Applications
If we're talking about adding a new field I would definitely agree with Charlene. But the sense that I'm getting is it's the value set related to an existing field that is what we're talking about and with the systems that I'm familiar with that is not the same kind of burden as adding new fields. Now, there is the whole issue of data conversion, when you're going from 5 choices to 20 choices then what do you do in your database with the patient, blah, blah, blah. But that's all accomplishable stuff. My sense is we should bite this one off because it is important to the quality strategy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just to make the point, you can't really convert the old data to this data.

Judy Murphy – Aurora Health Care – Vice President of Applications
Right, because—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... wouldn't be possible.

Judy Murphy – Aurora Health Care – Vice President of Applications
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, exactly. And there are also parts of the IOM report in terms of how this stuff can be done. And I think maybe we need to look at the other pieces of that that are called that and make sure we're picking up, just to get to Josh's comment, make sure that we're picking up all of the pieces that are critical here, and some might be stage three pieces. But I think just to categorize if people are going to be collecting

should definitely be a stage two piece. There's also stuff on ... margin, DC and maybe that's what Charlene means. There's a whole bunch of other categories—

Judy Murphy – Aurora Health Care – Vice President of Applications
I think that could have been, if we can clarify, because I got a lot of pushback on this one. There are thousands of these things to do, so a lot of pushback from the community on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think one thing that would be reasonable here would be to specify that in areas where we're just talking about different selections in existing fields we can call those out for stage two. But if they're additional fields that need to be added we could look at that as a stage three requirement because that's not something that people would be collecting and having to re-do. Would that be a reasonable compromise? Okay, do we have consensus on that then?

Art Davidson – Public Health Informatics at Denver Public Health – Director
From our own experience, having done this a little while ago, one of the problems with that is race and ethnicity were commingled, so there was not a field for ethnicity. I agree with Neil, but I just want to make mention that Charlene does have a point, that these fields are not necessarily established in all these registration systems.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So as a default, since we don't have any leverage over the registration system, it could be a provider responsibility. Okay. As we're learning ICD-10 ....

W
... also.

M
So did we vote?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think 80% find granularity, HIT ...clarify what that means, and ADT is still allowed.

M
Correct, and not any new fields.

M
Right.

W
Right and we're talking—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... language are going to be required.

W
I'll ask on this. I'll check that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. You can't do the new formulation without separating race and ethnicity. That's an absolute in terms of how you capture the information. The next few I think we have no changes. The CQM of course is going off to the problem list, the active meds, the active med allergy list, vital signs. Did we discuss whether it's just vital signs present or each encounter?

W
We might have.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Pardon me? Then there was a to-do, which was to check the age when blood pressure is relevant for ....

M
What I have is we talked about every admission but not every visit, so hospital ... but not every provider visit, and then we ended up with leave alone, whatever that means.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's vital signs present, I think.

M
During recorded—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
During recorded ... so that's how ....

M
We still don't have the ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. It says the AAP recommendation is three years, not two and so I think we would want to clarify that.

M
Three years?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Three years, yes.

M
Okay. Well, I would recommend we go ahead with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So that would be the stage three reporting period—

M
... for the outpatient and inpatient ... reporting period.

M
Okay. They're going to get vital signs every admission ....

M
Right.

M
It would be pretty crazy if they did.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one's on smoking status, and I have as our outstanding question whether we include other than firsthand cigarette smoke. I think for simplicity we'd better just put on the table we deal with firsthand cigarette smoke.

M
We had this discussion in this room, I think, once before about trying to get secondhand smoke measurement for children. I know that it was easier to just go ahead and put this forward for adult patients, but I know the pediatricians and family docs were interested in us having that secondhand

smoke measurement. I'm not sure of the state of affairs of measurement and validated questions, but that is something that is of concern to pediatric care givers.

M
I think the compromise we ended up with last time was leaving the measure alone but using certification to increase these things that you can state for smoking, which we may not even be allowed to do because the certification follows meaningful use. That was saying getting the systems to start being able to enter these data, that was where we ended up.

Farzad Mostashari – ONC – National Coordinator
I think similar to the last discussion around whether it's a new question or it's a value set I think the best practice here is not to include in one question whether someone is exposed to secondhand smoke as well as a primary smoker or a former smoker or someone who quit and is or is not. Those are two separate concepts and I think if you want to include it, it should be a separate question.

M
Maybe we can build it in as a signal for stage three, that we would like to have other things than primary smoker, particularly for the kids.

M
Certification can be pulling in new fields too. The fact that we said certified doesn't mean that ... to the same field. Is there a mechanism to—?

M
There's really no mechanism to get it into certification if it's not a meaningful use requirement, however. So that compromise was not a practical one.

M
What we can do is signal. That's the only thing we're allowed to do.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So the—

Farzad Mostashari – ONC – National Coordinator
In general, our policy has been that in order to include something as a certification requirement, that there's a hook to a meaningful use requirement except in a couple of things around privacy, well, no, even privacy and security. There may have been a couple of exceptions to that. That's just in our general policy, but if you feel very strongly that you want to cleave the link between it having to be in meaningful use in order for it to be in certification, that's certainly something you can recommend.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
On the issue with this field, and again this is secondhand smoke, there's a mix in terms of what a vendor's collected to date, and some don't know because they're not sure exactly what you mean, but the feedback is relative to the National Quality Standard, or Quality Strategy, and this can be collected in about 100 different ways. The work to start to standardize that value set needs to happen, and when that happens then I think it's a candidate for capturing a consistent way. So it's captured across some systems you would expect but in different ways, but a lot of different ways to capture that data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually maybe that is one of our entrees, so if we point out this problem that we don't have a standard value set for smoking status, we hand that to HIT Standards Committee, they can start incorporating that into certification criteria going forward. So one they can help us figure out how to create a standard list, and two, move it in towards certification and then of course ONC can decide what it wants to do with the certification rule.

Okay, good point. Then I think we did CDS already, we accepted the public comment for redefinition of CDS, the drug formulary we acted on. For the advanced directive I have a little question on whether it's worded exactly how we said it last time, advanced directives, that 50% of patients over the age of 65 have recorded the result of the advanced directive discussion and if there was an advanced directive then have it also in the record. So one of the issues is how do you cue in the reader how up to date this is, and what we said was add a date and time stamp, so at least just like medications this is what we do with medication list, for example, is at least give the reader a hint how recently has this been reviewed.

Another question, is this your entire patient base of 65 and older or is it those patients who have been seen in the reporting period? Actually, how is it defined in stage one?

W
We use that ... too, this encounter or there are the unique patients. This feels like a unique patient because it's a patient-centric item, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Then we have the—

M
... reporting period.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... the reporting period or active patient. We have to define one of those. I think we've used reporting period before and I think we should continue with that. Different practices define active patients differently. NPQA has their own definition, it's too ambiguous. I would use the reporting period.

M
We are going to see the word "active patient" in other criteria, so probably we're not going to .....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then we're going to have to create a definition and it's probably not going to agree with anybody else's. we want people to have an opportunity to achieve this, so you're going to get there and you're going to say we want this in 50% and people aren't doing it now. If you say within the reporting period they train their staff at the beginning of the reporting period and they need to capture around 50%. If you're going to have people look back a year and they haven't done it, you have to collect around 100% of your people to be able to meet a 50% threshold. I think it should be reporting period.

Judy Murphy – Aurora Health Care – Vice President of Applications
I would agree with Neil, only because you don't necessarily have the opportunity if they don't have an active encounter during a reporting period as we phase this in. Maybe stage three we can look at your panel of active patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you're right. There has to be a way to get there, and so reporting, at least you have an opportunity to touch stuff and you have something you can do. As the provider you have this process in place as they register, whether it's an inpatient or an outpatient setting, so that seems fair.

Judy Murphy – Aurora Health Care – Vice President of Applications
One other thing, Judy Murphy again, moving to 50% of them actually having one versus recording a status of I have it or I don't have it, is pretty major. I think—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... 50% recording the status and if they do have one then—

Judy Murphy – Aurora Health Care – Vice President of Applications
Only if they have one, got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Is that clear to folks?

M
....

Neil Calman – Institute for Family Health – President & Cofounder
This would be for both providers and hospitals 50% of patients, I think it should be 65 and older, yes, 65 and older who are seen during the reporting period have recorded the result of an advanced directive discussion and the directive itself as it exists with a date and time stamp.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. That helps people assess—

W
....

Neil Calman – Institute for Family Health – President & Cofounder
Yes, that's new.

M
So that's ..., right, so that means ... have a copy of the draft.

W
....

Neil Calman – Institute for Family Health – President & Cofounder
Fifty percent if it exists.

M
No, 50% have an indication.

Neil Calman – Institute for Family Health – President & Cofounder
Fifty percent have it indicated and you have a copy of it. That's the way it's written. Fifty percent of the people have an indication and you have a copy of it if it exists. So you're only going to get a hit on the numerator here if you identify that the person has it and if you have a copy of it. That's the way it's written.

W
I thought it was the discussion, but you're probably right.

Neil Calman – Institute for Family Health – President & Cofounder
The way it's written here I think you would have to meet both, it's an end.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The question is if you have one and you don't have a copy of it, is that a zero or a one in the numerator? The way Neil's reading it is zero. It's a composite score.

W

We want it to be a ..., I think. So we have to write it a different way.

M
According to this—

Judy Murphy – Aurora Health Care – Vice President of Applications
You want the discussion to happen, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We want this to actually happen. We already said that, though. Are we adding to that and saying that we also want it to be present in your records, if it exists, that you want to have a copy in your record.

W
... period between there instead of an "and." "And if, yes, it exists we expect a copy in the record 100% of the time." See, that's your point, that you have another—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... to say if it exists we expect a copy in the record 50% of the time.

W
 ... how do you even know it exists?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's what we're—

W
Because we're asking the question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
....

W
... composite measures.

M
You'd be checking it off and then not putting it in and getting a—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... a double denominator. What we're actually doing is it's two separate criteria. The first criteria is the denominator is all your people 65 and over and the numerator are people who have advanced directives noted. The second criteria is of all of those people of the denominator, what percentage of the people do you have in your record. I think it's important that that's a better way of doing it for now because we really do want to encourage people to have it in their record, but we want to make it usable. Because in the exchange, once we get people interacting then the hospital will have access to it if I have it in my record and that will be important.

M
It's clear that it's only of value if it really is in front of your face. That's—

W
The status was only meant to get us to having it available.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And if we loosen it up to only during a reporting period at least, again, people have a chance to qualify for this. Fifty is still pretty high for a new start and for getting it in there. If we like the notion of composite, meaning the value is only there if we have it, then do we relax the threshold for stage two anyway?

M
I'd like to suggest that we keep those as separate measures, because if you think about the future as we're moving to exchange, the fact that somebody says, yes, I have it and it's with my primary care doctor, it should be okay for a cardiologist. They don't need to have a copy of it in their record and every provider doesn't need to have a copy of it. It exists somewhere. So at some point we're going to be happy saying, yes, it exists. I just did one when I was in the hospital last week and that's okay, because I don't need it in my record. I can access it through the exchange.

M
So you're cascading it then?

M
Yes. I think that those are two separate things.

M
And you want the second one to be 50% or—

M
Yes, 50% of 50%.

M
It's just a proposal.

W
Only people greater than 65.

M
Sixty-five or greater, yes.

Farzad Mostashari – ONC – National Coordinator
Is it unnecessarily complicated, I guess is what I'm wondering, to create two denominators—one of the things that we want to do is reduce burden of reporting on this. I think if people feel that the composite, 50% is too high maybe just reducing that may be an alternative to creating two separate measures for this one item.

M
But then you're not going to ask. If you lower the threshold to 25% then you only have to ask a quarter of the people. I guess what we're trying to do is get everybody to ask and then to collect it as many times as is reasonable. I don't know.

W
Back to Paul's point about it's only of value if you've actually got a copy of it somewhere, I'm just trying to think it through because I think Neil's point about the exchange scenario makes sense. But then if you're a cardiologist and you know that it's somewhere but then there's a need in the cardiologist's office to know what that says, are you going to have time to go pull it from somewhere? And what happens if you go pull it and it's nowhere to be found because it's not been recorded?

Neil Calman – Institute for Family Health – President & Cofounder
One other thing is, as we ramp up part of the purpose of asking is to streamline the discussion. There may need to be time for discussion, but also if they already have one, you say could you bring it in at the next visit, that would be a scenario. You're not going to ask them to take a separate trip, and they don't carry it with them, so it's unlikely that we can even achieve 50% getting started, it seems to me.

Farzad Mostashari – ONC – National Coordinator

Neil, is your issue addressed if we clarify that it's not that the advanced directive, regardless of where it was originally obtained, needs to be available? Is your concern that we don't necessarily need every eligible professional to have the discussion de novo and to record potentially conflicting advanced directives? Is that your issue?

Neil Calman – Institute for Family Health – President & Cofounder
Yes, and also this is one of the things, I think as we're talking about exchange this is one of the real values of exchange is to be able to ... advanced directives.

Farzad Mostashari – ONC – National Coordinator
I wonder if it's clarifying, as we have done with some other instances in stage one, that the results of an advanced directive discussion needs to be available within the electronic health record, and clarifying that it doesn't mean that you have to have recorded that in the initial instance. It could be something that you got from somebody else. Does that meet your concern?

Neil Calman – Institute for Family Health – President & Cofounder
Maybe what we can do is call out that the location needs to be identified, so people say we're asking whether it exists and where it exists if it's not in the electronic health record. Can you do that? That's really what we're interested in.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't know. With HIE in its current state I'm not sure that what you're suggesting is feasible.

Farzad Mostashari – ONC – National Coordinator
I was suggesting actually that they actually be able to produce a copy of the advanced directive within their own electronic health record. I'm not suggesting that they add a URL to it. But they have to have it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The current state, at least in most hospitals today is you can document that you have the discussion and then if you have it most systems store the scanned copy, and again there's variance of that by state and you don't know is it the most current and all those kinds of process issues around it. It seems like right now we want to just make sure that we get it online where it exists.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that would argue for the composite, and I think it would argue for a low, because we're just wrapping up. Even if this exists to get the stuff in our records, I'll just throw one number out, like 20%, because it's going to be slow starting initially.

M
I think I like the way the conversation's going. The first thing is 50% need a conversation. Then to state what is the percent of advanced directives that exist in this EP or EH's possession, because it may turn out, as Neil says, that it lives somewhere else and that what we want to know in stage two is how often do you really have a copy of it available. And if we don't have it, then we know in stage three that we would start pushing for, as suggested, the exchange of this, or making sure that it could be exchanged. At this point I think it's make sure they have a conversation and give us the percent that are available in your system. Then we can target taking advantage of exchange.

M
I don't know whether you meant it this way, did you want to keep the 50% discussion—

M
Yes.

M
... and then just have a reporting with no—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Exactly. I don't know if Neil knows if the cardiologist has the advanced directive, he may send a person off to bring in next time to his practice and then the person forgets it. At least Neil has had the conversation and we're just getting an idea of what's available to Neil at this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George, we need to have at least reporting otherwise it won't be in certification. That's the bare minimum. Then the question is, are we ready to start? Then the question is, do you do 10% of the ones where you say yes, have to be in the system, that's your low threshold versus, in effect, attestation or the thing is enabled or employed?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's more than attestation, isn't it? The fact that I store it is that attestation. The percent that I have without a threshold is reporting a number.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, yes. Okay, so that's a compromise of saying we would like to stimulate the discussion and that's keeping the 50% percent, and then having a reporting requirement, which actually makes it certifiable, of the percent of the yeses, they do have an advanced directive that's part of your system, a successful—

Farzad Mostashari – ONC – National Coordinator
... imposes the same reporting person as Neil's initial ....

M
Yes, ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you think, Farzad, that we should just back off to the percent that had a discussion?

Farzad Mostashari – ONC – National Coordinator
I thought that the composite, as Paul had said, is it available. If someone had a heart attack in your office you want to pull up the record and see if they—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's where we're headed, right? That's the only ... things, honestly. Because of our early part of the ... it's a 20% just bring out any number. How do people feel?

W
This is a core objective, and so it's not like they're going to be able to defer this. I suspect this is one of those things that may, if we pick a high enough lower threshold it will be easier to do it for everyone and I don't know that this is something that has to be process oriented.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So instead of ... thresholds, you can just pick a lower than 50% and achieve the same thing. Rather than complicate it by having two thresholds instead of 50%, say 40%, and that lets you put a yes they have it but I didn't upload it and that counts towards the other number but you're not worried because it's a lower threshold to achieve.

W
Are you saying a composite?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Don't do a composite, do it as it is. If you say yes you have to have it and that's the only way it counts, but because the threshold is lower you're not so worried about it. I don't want to create a disincentive for people where they start saying no, they don't have it just so that they don't have to upload it. Is this going to be another one of those specialty real problems? Dermatologists, ophthalmologists, people are going

to start collecting advanced directives. I think what we're doing is we're moving people, if you're talking about trying to keep things at a reasonable state here, I think what we really want for those folks is for people to ask whether it exists somewhere, whether they've done it. And I think as a primary care person I'm fine with 50%. I would love to have 50% of them, but if I think if we're thinking across the spectrum of providers that it's not reasonable. I don't even think dermatologists should be asking people about advanced directives. I'd rather have them spend their time checking their bodies for melanomas than starting to ask about advanced directives. We can't just keep calling out things that don't make sense in the current way that healthcare's practiced.

Farzad Mostashari – ONC – National Coordinator
In the stage one final rule we talked about the rough framework for how we set thresholds. It strikes me that the situation for providers and hospitals is very different here. In that framework we said if it's something that's the usual practice anyway and we're making it electronic then 80% was the threshold we set. One could argue that for hospitals having an advanced directive is critically ....

W
Standard practice.

Farzad Mostashari – ONC – National Coordinator
Whereas for some kinds of providers it may be in the 60%, like it's done but it's not universal and then for others it's not part of the practice at all, as Neil is suggesting. We don't have the same mental model of who we're talking about when we're thinking about this problem, and it may be helpful to split that apart.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The quality measures you're allowed to declare that certain things are not part of my specialty. Maybe we could do that ..., this would be a different kind of criteria but it seems appropriate. All right, so I heard a few suggestions.

M
Tough one.

W
....
Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right, and probably this is a lot of the reason why CMS rejected our first one and then we came back. So they were right that it's very hard. Maybe it is easier to separate them. Hospitals, 65 and older, to ensure the best care for that patient and the most appropriate in that patient's mind you've got to know this stuff.

M
In stage one was it only hospitals?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
stage one is ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Sorry, the other thing to consider is for hospitals it has been, as far as the options ... moving it to core makes sense, but if for eligible professionals we're introducing it for the first time there could be, keeping it on the option set for. I know that this potentially introduces systemic structural issues, but Karen

pointing out that the option menu is good when you have some providers who may choose to use it and others who may choose not to use it, another approach to the exclusion of—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a really good point. That would be a different ... than we have with our original menu, which was on the way to being core. This is actually a menu for flexibility and appropriateness to your specialty. Let's go back to hospital. We can actually leave this the same and we may want to add and make it scanned in, put it in there.

W
So have the composite for hospitals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Have the composite for hospitals.

W
All or none.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is 50% a reasonable one? Well, you bring it in. They would have you sign it in the admission process.

M
Or bring it in.

W
Yes, they bring it in.

(Participants speaking over each other)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And they're all different.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So do we want to add the "and it's in there," it's scanned in if it's available to the hospitals?

W
Yes, but we probably want a percent then, though, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, and let's make it a composite, and so is it 20 or 50?

W
... at least.

M
Fifty.

W
Let's go 50. Fifty is good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we'll add to stage one by making it "and if it exists it should be in the ..." because then literally on any unit in the hospital they can have access to it, and that's the goal. That's the easier half. The second one

is we're introducing for EPs the notion that it's a good idea for 65 and older to have this discussion but raise the awareness and we would like, and again it's still no good if it's not there, but we're starting from a much lower baseline. So, one, do we want to introduce it as a composite or starting out with the discussion, and then, two, entering the flexibility of optional menu and this purpose is mainly for the may not apply ....

M
I would say that we should use the same criteria, 50%, because if it's relevant to my practice I want to push to make that happen as much as I can to get them in. So primary care providers, people for whom these discussions are very relevant, should do that. If they're not relevant or if people feel that this isn't part of their practice then they can opt out of this.

Neil Calman – Institute for Family Health – President & Cofounder
I might only tweak that by saying, from going from zero to fifty at one and making it optional just invites not taking this because you want to encourage people.

Judy Murphy – Aurora Health Care – Vice President of Applications
I think, Neil, there's also that whole issue of I might be going to see a dermatologist and I just had a heart attack a month ago so I have an advanced directive so I'm going to be answering yes, which would then put the burden on the dermatologist to try to get a copy of it.

Neil Calman – Institute for Family Health – President & Cofounder
No, the dermatologist would just opt out of this measure saying it's not relevant to their—

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, because—

Neil Calman – Institute for Family Health – President & Cofounder
They wouldn't choose it from the menu. They would say this is not relevant. We still have these specialty hearings coming up, which I think will help us define other things on the menu that would be more relevant to those specialists.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we're either going to have or not have menu items at the end of it. If you have one menu item that I don't know what it means at the end of all of this, right, I guess you can have more than one and it can't be menu items that are all relevant to the same person and not relevant to anyone else. So if we're doing menu as opposed to exclusion the only problem there is how do we decide, how does CMS decide if the exclusion is reasonable? Who is allowed or not allowed to say that this is not relevant?

M
They could have a list ... provider type, so there could be provider type specialties.

M
So there could be provider type, if we make it menu then if we end up with one menu we just won't have it at the end.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's true, it will become an exclusion, if there's one. Okay, so I think let's go with Neil's and then I would throw it to 20%. I'd almost start with 10% just because of where we're starting from, because it's a composite starting from essentially zero and we're just trying to get people on board.

Farzad Mostashari – ONC – National Coordinator
It's currently zero for eligible professionals?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
There's nothing under eligible. It's only under EH.

Farzad Mostashari – ONC – National Coordinator
No, no, I—

M
Oh, you mean in current practice?

Farzad Mostashari – ONC – National Coordinator
In current practice for—

M
It is ....

Farzad Mostashari – ONC – National Coordinator
... 65 and older in internal medicine practices.

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We do this, for example, but I don't know that even after doing it whether we have a high percent that would meet the composite score. It's just not ..., but people would want to do this. So I think all we're doing is moving this along, but there's no reason to get afraid of it. So I'm just trying to make it get on the escalator.

W
I'll throw out something that I hope doesn't muddy the waters too much, but is it safe to say, generally speaking, that the majority of these are executed in the hospital setting? If what you're saying is that primary care doesn't do these, then where do they get done?

M
Not a lot—

W
So 10% may be too low then. I thought you were saying that it's not typical practice for this to be done even in internal medicine or primary care.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that it's done, that it's recorded in a structured, coded way, and that you scan it in. All those things are pretty low to have a composite.

W
Well, I guess where I'm going with this is—and it may not be relevant if it's more common than what I was gathering from the discussion, but this could also be something that we can link to exchange if it's true that this happens more frequently in the hospital setting. We've required such a high standard for that, that there can be a link at some point where we discuss exchange, on the hospital side, because in my mind if I execute an advanced directive in a hospital setting I should expect that hospital to exchange that information with my primary care provider. Then my primary care provider, if he or she has not done this, or does not do this as typical practice, will have it, which is the right thing to do.

Now, whether this is the right thing for us to require is a different question, but it sounds like what I was gathering from the discussion is not correct. I was thinking from what you were saying, when Farzad

asked what are current practices that it's really low, it's really uncommon for this to happen in primary care. But what you're saying is that it's not so uncommon. I know, Paul, you were saying this whole composite of the structured and all of that, that's a separate question. If we're talking about the requirement being different for eligible providers then let's make it as high as possible to start getting that be preferred practice in places where that's appropriate. I guess where I'm having trouble with this is if you're thinking about primary care this should be being done in every primary care practice. If you're thinking dermatology, probably not, but how can we treat those two differently other than through the menu option like you were saying?

Farzad Mostashari – ONC – National Coordinator
We could get more data.

M
... how many people have an advanced directive ... with their primary care provider.

W
I do, because every time I go in they force me. And I think—

Farzad Mostashari – ONC – National Coordinator
I'm concerned that we, Michael Barr and Jim Figge maybe could have had useful insights on this issue as well and I just think we have a factual lack of understanding of what the current practice is. I don't want us to either pick something that's too high or too low based on uninformed ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are two kinds of questions. One is, of the population how many have an advanced directive? Then there's of the population who are seeing a provider with an EHR, how many are on the EHR? I'm thinking that how many are in the EHR is quite low. The population is probably uncomfortably low as well, it turns out. So this is what we're trying to do. How would we gather the information do you think? Does the government know the population ones at least?

Farzad Mostashari – ONC – National Coordinator
We could also look back at some of the comments we received on the rule last time. We have that issue assembled.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We still would have it pretty open, I remember, as far as how many are in the EHR.

M
I want to go back to a second to the thought, what we're trying to do is get people to meaningful use that are electronic health records. So first of all, are we clear that all the electronic health records have a standardized way of capturing this information? Because if you're scanning these things, in, Charlene, are we going to be transferring these scanned images as part of our data exchange? Is that part of what we're doing, we're saying? Is there a standard way of doing this that we need to put out or call out so that we don't end up—it sounds to me like we're committing ourselves to a part of data exchange being transferring scanned images around that are going to be partially legible and not necessarily the latest copy. You have to open every scan to see which ones the latest one. I'm going to go to the exchange and find three different copies of scanned images. I'm going to be opening them all up to see which one was signed most recently and they're not even going to be the same form necessarily.

It sounds to me like we have some fundamental issues around this that we should address, which would be a way of calling out the need for standardizing the way the information is captured so it can actually be exchanged electronically and available in a different way. That that's just important as getting people to talk about it, is figuring out how we're going to solve this problem in the long run.

W

Yes, and I that's why I was pushing on the eligible provider. It seems to me like if we're fine with moving forward with just a simple scanned image, then we should set a higher threshold for that because that, in my mind, is much easier than what Paul was saying. If there are actual structured fields that an EHR, that in the eligible provider setting are not there yet, then that's a very different question with probably a lower threshold. But if they're structured fields in the eligible hospital setting, can those standards be translated into the products that are in—

M
....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
There's regulation around what these look like in these areas across states, jurisdictions. Acceptable advanced directives vary, so there is none. ... so the intent was, okay, if you've got one at least make it so that you can see it and make it visible, so that was current practice and what people are trying to do. Some systems probably can capture some of that advanced directive information, but as a rule, again, each one will capture it and put it in, in the format as they exist as best as possible. That is not common practice and standards don't exist for that.

W
So even requiring this in the hospital setting then will be valuable there in the hospital setting, but if people are doing that differently than when we get to exchange that's something that's not—

Farzad Mostashari – ONC – National Coordinator
I just want to caution that we not try to do the work of the Standards Committee and the Policy Committee. The way that we signal that something needs standards is by including, the way you signal it is saying this is included and the Standards Committee then takes those as are there appropriate standards to be used for that? If not, should they be developed? That's the way the process works, Neil, I don't—

Neil Calman – Institute for Family Health – President & Cofounder
I'm putting that on the table, because we haven't done that before. We haven't signaled back to the Standards Committee yet, but I think if we're eventually looking to have this in one place that's acceptable wherever you go get care, that we need to do that, and we should signal that now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And what threshold would you like to set for EPs? We kept the one for hospitals at 50%.

Neil Calman – Institute for Family Health – President & Cofounder
Twenty percent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'd even move it to 10%.

M
And then you're going to move it—no.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's only because we're going from zero, or near zero.

Judy Murphy – Aurora Health Care – Vice President of Applications
Ten percent having the conversation.

Neil Calman – Institute for Family Health – President & Cofounder
No, having—

W

... the same measures for ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. That really does start people I think in that direction. And people wanted to go there anyway, it will help put in place the infrastructure in EHR and then we ask the Standards Committee, because otherwise there's no HIE because we all code it differently. Okay, very good. We dealt with the EP note. It has to be searchable, in other words scanned notes, as all the public did not count. The last bullet, which is the 30% electronic MAR, I don't know that we finalized this. I think the latest I remembered was in use in at least one hospital ward or unit. Does that feel right?

M
Which one are you on? I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The very last bullet.

Farzad Mostashari – ONC – National Coordinator
Is it 30%, or is it in one hospital ward unit or is it 30% in one hospital ward unit?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually this is—

Farzad Mostashari – ONC – National Coordinator
No more 30%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No more 30%.

Farzad Mostashari – ONC – National Coordinator
No more 30%, got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No more 30%, just that it is in use basically.

Farzad Mostashari – ONC – National Coordinator
Got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They're on the escalator. It's this denominator problem we ... and I know you would know well. How do people feel about that? It's basically in use—

Farzad Mostashari – ONC – National Coordinator
Sorry. In terms of the denominator issue, I'm sorry, in terms of the previous discussions about comparing it to the pharmacy records ... was deemed to be overly cumbersome.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, there was a medication order, is it each and every piece of a med order? We got a lot of detailed pushback on well, how do you count the denominator, so we're basically trying to move it out .... It sounds like we've got a lot of nods here.

Farzad Mostashari – ONC – National Coordinator
Can I ask a question about the blues in general? The blue are new objectives not included in stage one and they're being proposed for stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Farzad Mostashari – ONC – National Coordinator
If someone is coming in on their personal escalator for the first time in 2013 or 2014, is the intent of this workgroup that all the modifications in red would apply to them, but the ones in blue would not apply to them?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If they're coming for the first time for stage one?

Farzad Mostashari – ONC – National Coordinator
Yes. If they're coming in 2014, their first year in this program they're on a personal escalator and they're, according to what we said in the final rule, they would be expected to meet stage one—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
stage one, right—

Farzad Mostashari – ONC – National Coordinator
... requirements.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... stage two.

Farzad Mostashari – ONC – National Coordinator
So the updated stage one requirements, is the intent of this workgroup for them to be everything, all the tweaks in red but not the additions in blue?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right now we aren't disturbing your final rule of stage one. And even in 2014 it would still be your current stage one final rule. These are all changes for stage two. So none of the tweaks, which are the red or the blue, would apply to stage one 2014.

M
stage one is set in stone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, as the first part of the escalator ride. stage one is set as the first part of the escalator ride. What accelerates is the timeline that people have to meet in stage three if they enter stage one later.

Farzad Mostashari – ONC – National Coordinator
There are certainly going to be updates to the certification criteria for electronic health records that need to be met to the interoperability standards. If you are recommending that, that stage one requirements stay frozen from what was done in 2009 through 2014, that's a decision or a conscious recommendation that your workgroup and ultimately the Policy Committee would be making. I just want to be clear, it is not something that is required by statute or our former regulatory signal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I think that we were assuming that we would keep stage one the way it is unless we found some reason where we "made a mistake," and that it was probably unreasonable even from the beginning. We haven't run into that situation yet, so we didn't see any reason so far to change your final rule of stage one. Another opportunity would be if you tweak stage one could it make in a better direction for stage two and stage three. So we haven't found those instances yet. Other things we've talked about so far, the one that might be eligible is this whole race and ethnicity ....

Farzad Mostashari – ONC – National Coordinator
I was just going to say that there may be certain things that change in the standards and certification criteria that would make it appropriate to have—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. Don't chase back the ...

M
... an addenda or an amendment to the stage one—

Farzad Mostashari – ONC – National Coordinator
Quality measures is another area where obviously we don't want to stay static on the stage one meaningful use quality measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just to clarify, a vendor is certified by stage, is that correct? Okay. No?

W
No—

Farzad Mostashari – ONC – National Coordinator
There's a new certification regime, a permanent certification regime that will be introduced and we have ... about how to deal with folks and when that kicks in exactly. But the presumption, and what we signaled in the past, is that folks would need to update the standards and certification requirements if they're entering in stage one in 2014 they can't be still using systems that were certified in 2000.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we had clarified this recently that they had to all be on the same system certification wise and there may be contradictions between stage two and stage one, for example, but you can't do stage one reporting any more, or it may be a burden to the vendor to do two sets of reporting that are contradictory. So that's where Farzad and Karen are coming from. On the other hand, I don't know if the first day someone starts doing meaningful use they have to do meds, lab, and radiology orders may be too much to ask for somebody who's just starting an electronic health record yet. That's a stage one requirement, which by the way you phrased it, it would have been a black and red one, which they would have had to do. So that may be too far. Things that the nation wants to report on, it's better the more that everyone's doing the same thing, that's where you're talking about quality measures and ethnicity, but that's not what we've been focused on in the last six months. That's where we are and that's kind of—

M
So they're certified by year and so that's probably what's generating your question about whether the reds mean anything because they're going to turn into new certification criteria that can affect the function.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Some are and some aren't, so obviously if we're just changing a threshold—

M
That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that it really is dependent on the type of thing. I think it is something that, Farzad's saying it should be considered by this group. It might be something to go back and look at each one afterwards to find out which are the things that really are dependent on a new set of standards and certification criteria and which ones are independent of those issues. Okay. Let's see, where were we? Actually, the next one is an example of that, this lab thing where we did not or the HIT Standards Committee did not push LOINC on the lab, possibly because it was a menu item. But one of the things that we heard is we certainly would like to have LOINC more integral to structured lab. Am I on the right one?

W

....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
After AD, which is incorporate lab results of structured data. The fifth one down.

M
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that was the menu item moving it to core. I wanted to make sure that at least the popular and available LOINC codes were embedded with the structured lab results.

W
Paul, today the systems are actually certified that they can store LOINC so if the data is inbound in LOINC code they can store them in that format. So the systems are certified to that capability today.

W
Many labs, though, are not sending LOINC.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was our problem of pushing on a ... which is we don't have any control over the labs, except for the hospitals. So maybe that was where our intervention was, was to make sure that the hospitals were transmitting LOINC codes. That in fact is what it says, LOINC on the EH.

Farzad Mostashari – ONC – National Coordinator
The HIE Workgroup, there are recommendations that I don't think are captured here in terms of incorporating lab results. I think they get more specifically at that issue later, I believe, right, Josh? Exactly your point, that the HIE Workgroup asked this group to consider whether a new requirement on hospitals in that they send data, where they send data to affiliated providers is they use—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, we use it under care coordination—well, this is as good a place as any, really, to address this. It's a funny thing we're doing it under the meaningful use but it's really a meaningful push.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Part of the issue of asking the hospitals to send lab codes, that would be the LIS system, not typically the EHR system, but in some cases the EHRs send it. So again you've got a mixed bag out there, so depending on—

Farzad Mostashari – ONC – National Coordinator
This is exactly analogous to the public health reporting—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It is exactly analogous.

Farzad Mostashari – ONC – National Coordinator
... requirement from hospital labs, where we included the LOINC requirement there. So the HIE Workgroup's concept is to extend that same pushing out requirement on the certified system where you ... through LIS or core EMR to extend that to where you send information to affiliated providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We had this exact discussion, so the IE Workgroup in there and with the IE Workgroup—

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... ,not the later one. Require hospital labs to send electronic lab results in structured format to outpatient providers, so more than 40% of labs sent electronically and adopt and test LOINC for most common substantive labs requirement to include LOINC should apply to both inpatient and outpatient lab tests. Then at our meeting we were talking about not moving meaningful use to certify hospital labs, that was coming from you guys, I think, that we were then asking meaningful use to do something that was being regulated separately, and that was the concern with adopting that. I guess it's not part of hospitals' meaningful use of EHRs to send labs in a structured format ....

Farzad Mostashari – ONC – National Coordinator
Well it is part of the public health requirement. There's certainly precedent in public health for that.

M
... the responsibility to send it LOINC.

Farzad Mostashari – ONC – National Coordinator
Why is it different?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How did we get that authority to require that, though?

W
Right, yes.

M
That's where I thought we had agreed that how are we going to know that this test is related to a specific disease so that identifying the type of test as it goes from the lab to the public health department? We need a standard by which the public health ... can consume the data and then use it.

M
That's the ... side, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There's a set of laws for sending data to public health and there's a set of laws for sending data to eligible professionals but then the hospital lab is acting like an independent lab and there's a business there and there's a whole regulatory structure for that which is different than the one. So I think you're right about— so I'm not saying no LOINC on reportable labs, I'm wondering about sending structured labs to doctors out in the field. I'm not sure we're regulating that.

M
Yes, whether it's in our scope. And in some sense—

M
We can still do LOINC and we can do it through reportable labs, but just so that the eligible provider who uses a hospital lab would receive structured data that's idiosyncratic and the EHR is not able to really use it in—

M
Then ... support—

M
But I don't want to have a lawsuit that says that I'm taking a hospital and disadvantaging it compared to an outside lab because they have to follow the rules that they don't.

W
Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not doing this to outside labs, but I am doing that to hospitals.

W
Yes, I totally agree.

(Participants speaking simultaneously)

M
Who thinks that that should be part of meaningful use? Public health reporting's different. There I think we can put LOINC on. But for this particular one I didn't think that was in our scope.

Farzad Mostashari – ONC – National Coordinator
Why?

M
The hospital's running a business and this is not about their use of EHRs. Their lab's a separate thing. It's on a separate system. It's not the same information system. Even if there were no electronic health records they'd still have their own hospital lab in there. And often it's a separate system, like we have two different information systems, one that sends data to outside doctors and one that sends data inside a hospital because they have different requirements. I don't know why I'm—

Farzad Mostashari – ONC – National Coordinator
What I'm asking about is the difference between the meaningful use requirements for hospital labs to be sent to public health in structured format versus sending lab results to affiliated providers. The reason why the IE work, I just want to clarify, the policy intent here why the HIE Workgroup identified this as a priority issue is exactly the pushing ... problem, that one of the information exchange priorities is to have eligible professionals receive lab data in structured format and the large national labs are doing it. That's not the area of concern. The concern has been in the ecosystem, that it's the hospital labs that very often have not made the investments or effort in standardizing their sending of the lab results to data providers. That's where the IE Workgroup in their analysis of the ecosystem has identified a challenge for the eligible professionals in terms of being able to, particularly in some rural areas, to be able to have their lab results in structured format.

So the IE Workgroup felt that if this is an incentive program that's meant to affect the ecosystem, that this could be a point of push to encourage hospital labs to do this. So that's the policy intent, that the HIE Workgroup, with their lens on this, their HIE specific lens on this, has identified. I think from a first principles basis I don't see a fundamental difference between this and the public health reporting requirement, which also pertains in many cases to the LIS system, or the interface engine, or however they're choosing to send that information. I think the question that folks need to consider is the burden on hospitals weighed against the benefit to eligible professionals and their ability to have that and the IE Workgroup recommendations.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the medium and the long term benefit is to have us going out with structured code, and the hospitals need to, insofar as they derive revenue from this, they need to be part of the solution, I think.

M
It does open up a large door to advanced directives could be required to be sent out by hospitals in structured form, like we could kind of—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that builds a burden on the hospitals that would—

M

If we had an advanced directive structured format we might go there, but we don't have that yet. We do have LOINC. We've spent enough effort building LOINC out over the last several decades and I think it's time for us to make meaningful use of it.

M
... phrase.

M
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is Charlene. I'm not opposed to hospital labs sending LOINC-based code. I think that makes a lot of sense. The problem is as you start to put the requirement on the hospital labs now have to meet this criteria, it's a whole other process that's outside of the domain space of achieving meaningful use with your electronic health record. It's another system that has to be certified and there's a whole wealth of systems that have to be certified. Today it would strike me—

Farzad Mostashari – ONC – National Coordinator
Charlene, aren't they already being certified as part of the public health if they're using them?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
They are starting to emerge. They seem to be they should be a feeding system. I don't know why they have to be certified. I don't think it makes sense. I don't think the intent was ever to have to certify lab information systems. It was never part of the thought process. As an unintended consequence they may now have to be certified, but there was never an intent to have lab information systems certified—

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I obviously worked with the IE Workgroup. I think given the larger intent of the overall program, which includes even from Congress a specific requirement about information exchange, this is pretty instrumental in the long term capability. I think it's our responsibility in our workgroup to indicate to the Policy Committee and ONC and the CMS that this is a critical long term capability that should get started now. There may be other points of view and requirements that have to be thought of, but I think we should take a fairly aggressive stance in advocating that to support the intent of the bill as a whole this kind of information exchange has to be enabled, and this is one way to start that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, David. I would agree with that. I realize it's not explicit, but I wonder if calling it an EHR incentive program was a little limiting and more so than suits the task at hand, which is to get this information to the places and people who can use it. And lab is so critical. As Art pointed out, this is not an unused .... Should we take a vote on this point? The point being that we include, from a policy point of view, having eligible hospitals push out their results in LOINC code, associated with LOINC code. In favor, or any further discussion?

Jim
Paul, can I ask for clarification? Could the hospital use an intermediary to convert the output from their laboratory system into an acceptable LOINC format as part of the proposal?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, it certainly could. Any further questions or discussion before we take a vote? Okay.

Farzad Mostashari – ONC – National Coordinator
I just want to say one thing. I want to clarify how we have dealt with certification, because I think it's relevant here, on the public health side. The requirement was that the hospital health IT system that's in aggregate certified needs to be able to produce a message that is conformant to the standard and includes the LOINC code. The only certification that pertains to that system is whether you can produce that appropriately conformant message. That's it. So we did not establish a certification program for lab

information systems and all the myriad of things that they have to do and meet and so forth. It was very limited in terms of the testing to, can you produce a message that looks like this?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the hospital was your client in this case. So the hospital issues a message that has LOINC codes. That was for certification.

Farzad Mostashari – ONC – National Coordinator
That's for certification. That's the interoperability test of certification for that requirement, and whether you used an information exchange to meet that, then that is what gets essentially certified, whether you use an LIS that's what gets certified. If you use an interface engine that's what gets certified. Whatever you want to use to produce that conformant message that is what's getting certified. I just want to be clear that we did not create a comprehensive certification program for laboratory information systems with all of their requirements and we don't intend to do so. You wouldn't be requiring this is if you were to take this step either. You would simply be saying can you produce this lab message and conform it to the standards that the Standards Committee sets with the vocabulary?

Jim
Just to clarify that statement one step further. If a state was setting up a central exchange for lab data and the state provided as a service the ability for hospitals to convert their output into LOINC conformant code, then if that state's system has certified, then any hospital that subscribes to that system would be able to say they're using a certified system, is that correct? Am I understanding this correctly?

Farzad Mostashari – ONC – National Coordinator
That would be a certified module. Any other questions?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
A question, what is the meaningful use criteria then, is it attestation that the hospital is doing this, or are we measuring something, number of outpatient providers, meaningful use providers? What are we measuring?

Farzad Mostashari – ONC – National Coordinator
I think you just read the IE Workgroup recommendation.

M
It's 40%, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an ... 40%, so—

M
Outpatient ... for more than 40% of labs sent electronically.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
To whom? Sent to any entity, to eligible professional outpatient providers? How do you want to define that?

W
You need a new EH requirement.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm just saying that if we're going to have a criteria we want to know what the denominator is. Is it people getting meaningful use dollars, or trying to, any outpatient providers, or is it only doctors? It probably doesn't matter because if they're doing 40% they can do 100%, so I'm not worried about the threshold. But if they have to count the denominator they need to count something.

M
Could this be attestation—?

W
Yes.

M
Yes, why couldn't it be attestation?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They're including LOINC codes—

M
Or just all labs sent. I guess the intent of the workgroup was 40% of all labs sent outside the hospital.

M
I think part of the problem is LOINC codes don't exist for every known lab, so you wouldn't be able to ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the attestation would be you're sending out lab results with LOINC codes where available.

W
This is a new criterion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Any other questions?

M
So we'll be going for 40% of all labs or—

W
This one you have to add a new criteria in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me try to state the criteria, which will be for eligible hospitals that can perform clinical lab tests that they produce the results in a structured format employing LOINC codes where available, and the conformance is by attestation.

M
Where available maybe too.

Farzad Mostashari – ONC – National Coordinator
The other option is to do the 40% to say that 40% of all lab results sent outside have a LOINC code in the ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fine.

M
Yes, I think ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So that's modified.

Jim
What if it's a specialty lab and there isn't a LOINC code for the work they do?

Farzad Mostashari – ONC – National Coordinator
They're eligible hospitals, Jim.

Jim
Well, there are specialty labs in hospitals, and those labs would not necessarily be able to send out 40% of their results.

M
But, Jim—

Jim
... code doesn't exist.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Jim, in the work that Regenstrief has done I think it's 85% to 90% of all tests are covered in the first 150 most common lab tests that you do, so you don't have to throw in all your specialty labs in this. All the CBCs and sodiums really make up the majority of all the testing in the hospital lab. You don't need to LOINC everything.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We'll need an exclusion in case for some reason the hospital lab is not sending out any CBCs and they're only sending out the specialty stuff and then there are no LOINC codes. So you need an exception. I'll try to restate it. For eligible hospitals that perform clinical labs that they return the results in a structured format, employing LOINC codes for 40% of the results of the return and qualifying by attestation. All in favor? Are there any opposed? Charlene and Judy, those two. Okay. And David Lansky, are you on the phone?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I'm in favor.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're in favor, okay. So ... and as George mentioned there's actually still more opportunity for comment and ONC will decide in the end. ....

Jim
And Paul, for the record can we make sure that Farzad's comments about the certification go along with this, with the intermediaries and so on, because that's very important for small hospitals to be able to go into an intermediary service.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Thanks, Jim. Okay, we're ready to move on to category two. We're a bit behind. We just did category two just yesterday. I have a couple of things that I'm not sure we covered. We did not cover the new criteria such as secure patient messaging, and I think what we decided, it's third from the bottom, let me change that, it's at the bottom of the screen now, that secure patient messaging online is offered and I think we changed it to in use, as opposed to a numerator/denominator. If it is in use then as many people who choose to sign up use it, but it is in use and core. There seems to be agreement, so that would be your agreed upon thing.

M
Is 30% still—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, in use, secure patient messaging exists and it's in use. The one after that, and I don't see it on here, maybe it's the next slide, no, it's not in here. It's the patient preference. Our question here was how granular do you want to be. My proposal on the table would be since this is really non-standard stuff, that

we leave it up to the local organization to decide. The purpose is for the local organization to be able to communicate with its patients in accord with their preferences. We do not have standards on how ... that on a national basis, but that's the goal, and leaving it to their local preference ... at this point ....

W
Paul, just a clarification. Is this EP, EH, which one was it? I forget this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George, do you have this? In our old version it's the second to the last one, patient preferences for communication medium recorded for 20% of patients. We ... that we were left open with the question of how granular it could be.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I know but somehow it got cut off in the one that we were showing.

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Patient preferences for communication medium recorded for 20% of patients. That would stay the same, and in response to the question that was asked from the public is, how granular would you make that. I think at this point, in the absence of a national standard, that would be left up to the local organization. Is that fair?

M
Yes, because it could not be a standardized set of—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not a standardized—

M
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does everybody have their own capability, etc., ... standardized set. And I'm not sure you would pass that across HIE anyway. Okay. I think we're on to care—

W
.... Is this for both, EP and EH?

W
That was considered part of the secure messaging.

W
Which one?

W
Stage three, provide mechanism for patient entered data. My understanding is that that was discussed, at least that information reconciliation was discussed as a use for secure patient messaging.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could be. We wanted to have a more structured way of doing that, and that's why we put it in stage three.

W

One other clarification question on secure patient messaging. I know we're taking out the 30%, which is fine, but I'm a little concerned that if it's just available but there's no requirement to offer it and there's no threshold that it will be this big secret thing, because we know that there are providers who have stuff available and they're not letting their patients know about that. So even though there's no threshold, should we leave the word "offered" in there to create the expectation at least?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That they're going to attest to the fact that the function—

W

The function's in use but even if they flip the switch, that they never told a single patient that they've even got this feature, then I don't see that it benefits anyone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So maybe we should change ... so would attest—

W

I think they need to attest that they're offering it. We'll leave off the threshold, but if we're going to do this by attestation and we're only going to require that they've got this capability but they're not going to offer it, I don't see how there can be any gain there for anyone. If we make them attest to having the capability and attest that they are offering it to their patients but leave off the threshold as we've agreed to, then that adds ... to it and hopefully some patients will then learn that they actually can get this and will then use it. Given that this is not a capability currently in the vast majority of healthcare, I don't think it's adequate just to say let's turn this on and not tell anybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the question is whether in use or being offered is stronger?

M

In combination.

W

Well, it depends on how we define "in use." I think most providers would define, because this is how I'd define it if I were a provider, I would define in use as being I've got the capability in my system and I've flipped the switch, but did I ever tell a patient that I've got it? Maybe not. But if I'm having to attest to the fact that I'm letting patients know that this is a capability. Even though I don't have to collect information, which I agree with the fact that we're not having a threshold, but I'm just concerned that if we don't indicate the expectation is more than just flipping a switch in their system that we won't have achieved anything for patients.

Jim

Could we go back to the solution that I offered yesterday on another topic, which is the Medicare eRx model, where we asked the professional to demonstrate that, say, 20 patients are using it, a small number, but just show that it's actually being used.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I was going to say that ..., Neil, did you—?

Neil Calman – Institute for Family Health – President & Cofounder

I was just going to say this is a different kind of requirement than most other things, in that what we're really doing is we're really developing a requirement for providers to change their complete practice mode, basically saying we expect that your practice will develop an ability to do pretty close to what we're calling out for electronic visits. When a person securely messages you and says I've had a headache for three days and blah, blah, blah, unless you're going to have an automatic reply that says if you just sent

me a message that says you're sick please call for an appointment, basically you've called out a requirement. We're calling out a requirement that people incorporate eVisits as part of their workflow, and I don't know if we're ready to do that. There's no reimbursement for those. Even at a threshold where right now about 13% of close to 100,000 patients of ours are using the patient portal, providers say that there's a substantial amount of time that's required to answer those messages and we're now having to build that into our—I don't know if the EHR is the tool to require that. I don't know if meaningful use is the way that we call out that there's a new way of practicing it and we're expecting every practice to be able to do electronic visits.

The second point I would make is if you're going to do this what are we saying about standards for replying to these messages and things like that. It's one thing to say you can message me, but it's another thing to say are we going to say that the messages have to be answered within 24 hours, 48 hours, that they're for non-emergent messages only. We're getting involved in something that gets deep into the workflow of practices and their capability of handling this kind of volume. Just one more point. I'm sorry. Again, you're talking about differences. There are places that have open access where basically patients can walk in and get anything done at any time. There are places that are cut completely closed access, where you can't be seen without an appointment. And secure messaging is a totally different role in those kinds of environments. It's a complex issue and not to take anything away from the fact that we think that this is important, but we should be clear what we're doing here and there's no reimbursement for this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil, would you be more comfortable if the messaging was more for administrative issues like scheduling an appointment or asking for medication renewal rather than bringing up a clinical issue?

W
Along the lines of that question, I want to point out that this is very different from an eVisit. It could be used for that purpose, but the purpose here, as I've understood our conversation, is to create communication. And meaningful use is a very appropriate vehicle and tool for doing that. I think that that might be something that we could leave up to the practice. If the practice wants to use this for eVisits, then fine let them do that. But we shouldn't say that they have to. But what we can say is that they have to communicate with their patients who prefer electronic communication using electronic means, which the whole world uses in every other area, which is e-mail, secure e-mail, secure messaging. This also, yes, I think Neil you're right, it does require a change in the way that practices do their workflow, but isn't that what we're about? I think you can do that without requiring this to be an eVisit.

And here's an example. Your example about a headache, the physician is not the one that has to answer this message. I don't think we should declare who has to answer the message or how frequently or how quickly. I think this is a way for the practice to incorporate this in whatever way works best for them, but they must use this means of communication with their patients because their patients and their workflows are using this means of communication in every other area of their lives. So if the patient has a question about a headache, then the physician practice can have decided ahead of time that their workflow for dealing with this is that the nurse practitioner is going to screen these, it's called team-based care, and the nurse practitioner can then probably answer that question about the headache. It is not an eVisit, it's answering a question which they would have answered anyway through phone, and they would have had to answer anyway by phone and probably the practice is going to find this much easier because it can decrease the backlog through phone, which has to be synchronous, which can be asynchronous. If the patient e-mails a question that then gets into the depth of the tale that really they need to be seen, that's easy. The nurse practitioner or whoever, a member of the team is assigned to deal with this and says you need to come in for a visit. Please schedule a visit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So you're talking about a triage function, so if we restricted this to administrative issues like scheduling an appointment and triage functions which currently are typically handled over the phone, would you be comfortable with that, Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I definitely wouldn't be comfortable with anything that's related to triage, because then you're talking about something that's got to be reviewed almost in real time. You wouldn't want somebody sending a message about the worst headache they've ever had in their life on an e-mail and expecting somebody to pick it up instantly and say then you'd better go to the emergency room immediately. I don't think that's a reasonable thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So your initial concern was that they would turn it on and not use it. So we just need to define in use meaning actual use in some way and leave it vague for ... reasons. So let's say that in use means actually being offered and used by at least some patients. You don't even need to put the 25, although it's kind of equivalent to Jim's ....

W
Yes, I'm not saying that there needs to be a number. I'm just saying if we're going to have this be attestation it needs to be attestation to more than just I have this capability, because that has nothing to do with use, and we're about meaningful use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was going to say in use means—

W
In use, and we need to clarify, I think, that in use means it's being offered. I don't understand what the hesitation on being offered is. And you can offer it in such a way that says—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're not saying offered to everybody, though. It could be a subset.

W
Yes, but why would you not offer it to everybody?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... that here, because in a different practice it may not—

W
Right. I think leaving it up to the practice as much as possible is good. I'm just concerned if we only say it's in use that most people, as I would if I were a provider, would interpret that as it's in use. I've got it on my system. I've flipped the switch. They can use it if they want, but I'm not going to bother to tell them about it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if this is a good point where we say this is not the only game in town. I think our contribution is to make sure that the systems that people have available to them have this capability. This criteria actually makes the certification criteria. That was one of our objectives. The other things that are going to move people are the market pressures, so this is something to talk about, the ACO, NCRM, etc. So I don't know that this meaningful use thing is forcing people to change their practice a la what Neil was saying, but I think what we do want to do is make sure that the capability exists in a secure way, that it's protected. If we leave it in use, an attestation of in use and offered to patients—

W
I think in use and offered would be good, yes. And make it attestation, leave a number out.

Judy Murphy – Aurora Health Care – Vice President of Applications
The only issue with offered then is potentially we have a burden to create a field that says this was offered ..., but not an attestation.

W
You have to have your—

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, you still have to attest that you offered it.

M
Yes, there has to be a way to audit it.

Judy Murphy – Aurora Health Care – Vice President of Applications
Attestation still means that you measure something. It just means you don't submit—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think it means that. How often can you be audited?

M
Yes, if you don't have a record of something and you get audited you have no way of proving that you did it.

M
... walk into my office and see a sign that says, please be aware that you're able to communicate with your providers electronically. The attestation doesn't have to be on every single record of every patient that came in. I can be attesting to the fact that there's a sign on a brochure given to every patient.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Who knows more about this? Karen, do you know about what constitutes an audit of an attestation?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Well, again, let me be clear that all of this is by attestation, even when you're reporting numerators and denominators—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That says' I'm telling the truth, right.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
That says I'm telling the truth. So the audit needs to be able to come back and look at something. What we heard in the NPRM comments was don't make me count something that I can't already count from the EHR itself because you're adding burden. That said, if there's something that you can say, okay, I offered this, it's at the bottom of my sign-in sheet or it's on a plaque in my office, I think that's something that's reasonable and we would consider that, rather than add to the burden of putting another field in EHR that then has to be checked off.

Jim
We should be explicit in what we say, so by attestation, you're attesting to the fact that you've got a notice or some kind of sign in your office saying that it's available, because otherwise auditors will interpret this in each of the 50 states the way they want to, if we're not clear.

Art Davidson – Public Health Informatics at Denver Public Health – Director
On the patient preferences for communication medium recorded, couldn't it just be that this is one of the media that are recorded? Couldn't you just say I have secure messaging in my practice and this is something I'm offering to the patient? Do we need another field? It's just another option in that field around patient preference.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know that it's the same thing as being deployed.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I don't think that he was saying that we needed to fully deploy this. It's just offer it.

W
Well, I think a reasonable person would expect that in most places and in most practices if you're offering it consistently to patients and you've actually got the functionality there you're going to have at least one person and one message during the course of a reporting period. I feel like we're arguing something that has already been decided. We had moved on from this. I just wanted clarification that we were actually having this be an engaged patient and families criteria as opposed to one of the other categories. Because if you only have the functionality there but you're not offering it to your patients it shouldn't be in this category.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'd like to move this to a vote because it's getting repetitive. All in favor of the language is basically that it's in use and offered to patients by attestation? Do people want to vote?

M
Yes.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any opposed? Okay, one opposed.

W
And maybe make a note about the clarifications that were said, because I think that's important so that we don't get people over-burdening.

M
I'm worried about the over-burdening.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And Jim and David on the phone?

Jim
I'm fine with it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, David?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

M
... is on the phone as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Joe, are you listening in?

W
Just to clarify, we also have the offering issue on the electronic discharge instructions. I know that was part of our phone conversation yesterday about how we would track the offered, so the second one on this slide.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right. So we decided on the 25.

W
I think my only point would be this clarification of the offered, that it doesn't have to be a field that's ticked. We would want to indicate that on this second one as well, except we have to measure the ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We actually voted down the offer. We basically just went to in use 25.

W
Oh yes, that's right. I should have looked at the ..., sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Are we ready to move on to category three? In number one the ... connections, improved care coordination, advance the slide here, yes, the first one here we had some options. Let me see if one captures it all, which it looks like it's option one, which is make sure there's a bidirectional communication in place and in use, and that is by NHIN Direct or through an HIE. I think the goal here, even though we don't have an NPRM for the NHIN governance, is you are actively exchanging information under the rules of NHIN's governance. That would be the goal. In the absence of that rule we're trying to give a couple of alternatives that are demonstrating that you're exchanging information. Now, we could have a number in place to show that, but the goal is that it's something that's in use. Alternatively, I guess an option too is you basically say, look, if you're exchanging summary of care information you've got something going, and that would be a way of saying it's in use.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
 Paul, this would strike me that we want to make policy that it's in use and that the Standards Committee then would therefore figure out how.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
 That was the feedback I was getting, to demonstrate the connection. I know we talked about percentage, or at least one external provider or something like that.

Farzad Mostashari – ONC – National Coordinator
Is David Lansky still on the phone?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
David, are you still on the phone?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I'm still on the phone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you have a comment here?

David Lansky – Pacific Business Group on Health – President & CEO
No, I'd only say that our workgroup wrestled with this a lot without any definitive conclusions. I think the preference was still to find other functionalities like the care summary delivery that reflected this. But we still have not come to a really happy conclusion on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me try what Charlene just proposed and see how this runs. To express the goal that you are exchanging, and the nice thing about this objective is that it specifies who you're exchanging with, that it's with external providers, i.e. not somebody on your EHR, that it's bidirectional and that it's in use. So that

can be the basis for which the HIT Standards Committee can say well, here are the rules about that. Again, I think the goal is whatever NHIN decides are the rules, those are the rules that qualify for this criteria. Then in a separate objective we have the exchange summary of care document, and that essentially creates a measurable something that you're sending across. How does ... feel? Would that capture the kinds of things that your group was interested in?

David Lansky – Pacific Business Group on Health – President & CEO
I think we were actually interested in strengthening the bidirectional exchange question but didn't have a feasible current way to specify that.

M
I think, Paul, the problem with that is that it reminds me too much of the other one that we split and ended up having to get rid of the one that—remember, we split hospital or EP under engaged patients and families. We had to split it and then we ended up with a mess and no one understood what we were doing. So I think if you want bidirectional think of a use case that actually needs bidirectional communication rather than just specifying in an empty way—

M
....

M
... and maybe you send a referral, you get a referral note back would be a bidirectional communication, although not everybody participates in that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We don't necessarily, in this particular objective, have to insist on bidirectional because then all of a sudden you're requiring somebody to do something to you and you have no control over that external party at the source. So what we're trying to do right now is basically create an HIE requirement that is tied to the standards and policies that get set in other ways. The standards from the HIT Standards Committee, the policies by NHIN governance as at least what we heard from recommendations from the NHIN Governance Workgroup.

M
We need to link it, but do we do it by having a separate objective or do we do it by picking one of our use cases and linking that to the Standards Committee, either summary of care, MEDREC, care team members and longitudinal care plan. Do we pick one of those or all of those to link?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Some of these things can be done on paper, it may be appropriate on paper and it may be requested, those kinds of things.

W
But I think it's important when we're talking about paper that it can be offered but that that doesn't preclude also doing it electronically. The discussion we had yesterday about the discharge summary, yes, most patients are going to want that tangible in their hands as they leave, but making it available to them later on electronically is also important because we all know how chaotic hospital discharge is and that paper often gets lost. So I don't want to get hung up on the paper issue, because I think that's a choice for the patient that should be offered in addition to the electronic not—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So maybe we—

Farzad Mostashari – ONC – National Coordinator
Sorry, I'm wondering if it might make sense to go through the other concrete information exchange use cases first and then ask the question, do we need anything else?

W
... thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was the next statement out of my mouth.

W
 Great minds think alike.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's move to summary of care, as one example there. One of our thoughts was that, again, instead of the 30 times 50% is to figure out some low percentage, it's almost a composite measure that says 10% of your summary of care documents are transmitted electronically, some low percentage are transmitted electronically. That seems to, one, you're going to have to have a way of doing that, that's an HIE function; and two, you obviously have the capability and you make use of it where appropriate.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
To comment on the paper, it seems like this paper requirement we had in stage one will become less with stage two because you've got other venues to get asked that same kind of information under patient engagement. So I do support the direction you're going to actually make this a data exchange requirement. Again, I've had feedback both ways. I just want to connect three or the threshold. But I think at least it gets the data flowing and I think it will work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now, is 10% even too high for rural communities where you just don't have the "recipient," that's the word that I have.

M
I would keep it simple. So 10%, the exclusion is maybe you have to work at an exclusion, and the exclusion is you go to paper. If it's no exclusion then it's 10%, and I don't even know that we'd need to continue the—pick one threshold and it's electronic, so summary of care becomes electronic unless you have a legitimate exclusion.

M
If you have an exclusion you still have to do something, you have to do it on paper.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that still speaks for having 10%, are you saying?

M
Yes, just as an exclusion 10% is low enough.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. I don't know that rural communities can achieve 10%—

M
... —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... exclusion, correct. Okay, so let me try to restate that. A summary of care document that still has to be defined by HIT standards is exchanged for transitions of care and referrals and you have evidence that 10% of those are transmitted electronically. Now, what do we do about this denominator again?

M
How did we do it last time?

W
Now, this was EP before—I can't remember if it's EP and EH this time or are we still just talking about –

M
I have to look.

W
Oh, I thought we were doing both because it's discharge. I've got discharge in here now too.

W
I think it was both.

W
I had on referral and on discharge in my notes.

W
And how did we get from 30% to 10%?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's 30% of 50%.

W
Oh, I got you. So is the question on the table how do we work on the denominator?

M
Yes. We need to figure out a—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
 How did we do it last time? What we had was the transition—

M
... setting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you have it at your fingertips, Josh?

Josh Seidman – ONC
I have the final rule right here. Is it the summary of care record?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Josh Seidman – ONC
Yes, the summary of care record is for EPs and ..., and that's 50% of transitions of care.

M
Is that how you—

M
... transition, that's the question.

M
... one provider to another provider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do you count the denominator, how do you figure it out?

Josh Seidman – ONC
The rule, I have it right here, and it just says "transitions of care and referrals."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But it was—

Josh Seidman – ONC
Let me see if the discussion goes better.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The denominator accounted for by transition of care from one provider setting to another so—

Josh Seidman – ONC
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that is the denominator—

W
How do you know that?

Josh Seidman – ONC
... transferred to another care setting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do you know that?

Farzad Mostashari – ONC – National Coordinator
I would guess that practically speaking hospitals used it on discharges, denominated it on their discharges, and I would guess that EP tended to denominate it on referrals rather than try to do this comprehensively. That would be my guess of how actually people have been interpreting it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What happened was the original requirement that meaningful use recommended was the HIE one, the ability to be able to get ready to send one in stage one, and that was that objective one that we just talked about. In hospital systems you're ready to exchange but you didn't actually have to do that exchange. Then when the final rule came out it added in the care record summary the thought was always in that first requirement we were ready to exchange that care record summary, so in the hospital this care record summary does not apply today. It's only to the EP. So combining them, I think, makes sense because that was the intent, we were ready to exchange in stage one, and we would count in the hospital discharges, on discharges, so we would know that. On the EP side I don't know how they count today. That's the question.

M
... menu, right? So people probably ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And actually in the listing it's one that they have trouble with.

M
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And the difficulty is trying to define what a transition is, that's the piece that we have ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we have a clear definition of transition. We just don't know how to count them.

W
If we go with George's suggestion of just flat out requiring it electronically and lower the percent and then having an exception and in the case of only for those providers who do not have any exchange capabilities. And then for those that require paper, can that somehow take care of the denominator issue in the sense that you don't really necessarily need—well, if we set a percent, sorry, you do.

Jim
This is Jim.

W
... not count, because everything will be electronic. Maybe then we would need to go to a flat number?

Jim
I can't say enough from the perspective of the states, and probably also CMS, as far as I know, these ratios where denominators cannot be automated are very, very problematic and I would definitely suggest getting rid of all of them and putting in something that can easily be counted automatically by the system.

M
As Farzad was saying, can't you count the number of referrals and discharges?

Farzad Mostashari – ONC – National Coordinator
Discharge is easy.

Jim
Counting referrals when—

W
... CPOE.

Jim
Counting referrals for an EP is not going to be easy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... have ... right now.

M
What did Jim say?

Jim
Counting referrals by an EP is not going to be easy. It's got to be something that's already captured on the system and it's already automated. The ratios in general are hard to count because some of it's still on paper. When you've got a mixed electronic paper process you can't capture that data electronically. So the ratios are extremely problematic and they're going to be a nightmare for the states that have to audit this. All 50 states and CMS are going to have a nightmare auditing all these ratios where you can't capture the denominators. That's going to be a huge problem.

M
Wouldn't we have those referrals made through CPOE?

Jim
They don't always get made that way. Some of them are phone calls. Some of them are on paper. You're not going to capture all of those so you're never going to know what that denominator is.

M
Our goal is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're trying to get them on CPOE.

Jim
Yes, but the point is not everybody's there so it's not going to be that way. In real life they're not all going to be on CPOE and you're not going to know what these denominators are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, can I just make a comment? They're not going to be on CPOE if you're counting CPOE meaning that the referral's being transmitted electronically to a specialist. You can count the denominator. Even if you put an order in for a specialty consult and it prints a referral, you can still count that electronically in the system.

Jim
That's assuming it got in the system, and that's an assumption that you can't make because it doesn't always happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Think of a smaller provider, they're probably going to have—

Farzad Mostashari – ONC – National Coordinator
This is Farzad. This has been a generic issue that we want to have reduce the burden on providers, we want to use data that's available within systems. I think it's an important note that Jim is striking. On this measure in particular I want to underscore the importance of this measure to the priorities of the health IT agenda. I just want to note that within the National Quality Strategy itself, if you look at the appendix, one of the illustrative measures is the one specifically that caused, I think the only one, that specifically caused the health IT and it says percentages of providers who provide a summary record of care for transitions and then for referrals. So I just urge us to find a way to make this doable, feasible, workable, measurable, but this is a very important one.

M
So we have to look at the options. One is for medications, we don't want to count how many paper orders we have, so we have unique patients. Is there a unique patients' equivalent? They don't have a medication list. With the patient mix we wouldn't know a reasonable percent threshold established.

Farzad Mostashari – ONC – National Coordinator
The only other comment is that we've heard a lot from long term care providers who are not eligible for the program and this is an important point of intersection is the transition of care between acute care and long term care, is an important point of connection. And enabling that electronic communication is an important policy imperative ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Fortunately, at least for the hospitals, which are most likely the sources of that referral transition, we have those counted. I think it goes back to the EPs. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I just want to make the case again, I think it's critically important that we call out here the need to enter referral orders and transitions electronically again in the system because there's all kinds of things. Once again it's like the other cases we've made for CPOE, if you're reporting on trying to figure out what percentage of your diabetics have seen an ophthalmologist, you need to record the ophthalmology consultations. If you're making a transition to somewhere, you're going to want it recorded in the electronic health record where the person went and where the information is. So the old pick up the

phone and tell somebody something that they forget five minutes later is exactly the process we're trying to undo.

We're not trying to say let's support those rural providers who pick up the phone and tell somebody something over the phone and that's fine. Those are the processes that have been problematic and have led to medical errors. What we're trying to do is say let's do this in a consistent and methodologic way so that people get the information they need at these transitions of care. The only way to do that is to enter those orders so that they can be retrieved later, they can be looked at, and I think it supports all of the new models of care that we're developing. If you're going to enter those transition orders electronically, they can be counted electronically very easily. I don't want to just assume that it's not something that's countable. It is countable and it's countable electronically if you enter them. So people are saying to people you need to enter these orders electronically because we're counting these as a denominator but that's not the only reason we think they should be entered electronically, because it's good quality care.

Jim
Neil, I have no argument with anything you said, but from the perspective of an auditor you're making an assumption which is that they did enter it and the auditor can't make that assumption. The auditor has to look at everything. You can't go in to an audit with that assumption that it all got entered, so that's my point.

Neil Calman – Institute for Family Health – President & Cofounder
No, you just say electronic orders.

Jim
Yes.

M
"N" percent of people with electronic order for a referral has to be done electronically. Then you're creating a little bit of ... entered electronically, but now you have a measurable thing.

Neil Calman – Institute for Family Health – President & Cofounder
With all due respect to the people who are funding this stuff like you, Jim, and CMS, if we use that as a criteria, that unless you can audit it and somebody can come in and count it, we can't put it in as something that moves the system forward.

Jim
Neil, the reality is that the states have been directed to audit this stuff and we have to have a way to do it. We can't audit something where you can't measure it or count it. That's the problem that we're encountering here, there's no way to do it unless it's captured electronically, but there's no way that you can walk into a practice and guarantee that it actually did all get documented electronically. The auditor cannot make that assumption.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In order for us to move along, because I think we are behind in our agenda, let's try not to repeat a point. So the options are, we need to make sure that the information is flowing at points of, and I'll word it as "or" either transitions or referrals as an ... and figure out how do we—the transitions is easy for the hospitals, so that we've got that nailed. Now, referrals is probably easier for the provider and how can we quantify it, I won't use the word "ratio," how do we quantify that the stuff's moving? Maybe it goes back to the 25. It obviously tests the system because it's going to go electronically, it has to go in some understandable format, and anybody with any panel is going to have 25 referrals. I'm just trying to back ourselves into a corner where we say, okay, well, that would make sense. It would prove something. And people are not deliberately out, or most people are not deliberately out to undermine the program.

Neil Calman – Institute for Family Health – President & Cofounder
I'm comfortable with that, because once you establish that you realize how easy it is to make a referral and transfer the appropriate information, and people are going to use it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're seeing some nods here locally; out there in telephone land?

Jim
It sounds good to me.

M
So you're saying hospital discharges—

M
Ten percent.

M
That may be high. I'm just thinking—

M
It could be high.

M
... electronic summaries because you're sending it to thousands of doctors, so 10% of them are going to take it electronically.

W
But you were ... long term care and you could include D&A. So that's where you might also send it at a hospital discharge. It's not just to the provider, right?

W
And we're also doing this in the context of ACOs where you're going to have to do the—

M
....

W
... going to have to be worked out.

W
It sounds reasonable to me if we count all the places people go—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we'll need to qualify that it's 10% of all discharges and that's not just to eligible EHRs, intended recipients. So that's point one for hospitals.

W
Are we also saying that this, going by what George said early on, that the expectation is that this be done electronically and only if you have zero capacity to do that ... paper, or is that a separate topic that we'll decide later?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're talking about the exclusion, and we did want to come up with an exclusion.

W
It seems to me a little simpler to do it that way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You would have to attest that on the hospital side that more than 90% of your discharges go to people who cannot accept this information. It's a little bit like the attestation about zero denominator, if you're going to have one you've got to say I was forced to .... I couldn't qualify for this.

W
I'm thinking that part of the benefit of going that route is it almost forces people who have any capacity to do the majority, to do way more than the 10% as the receivers can do that because there's not an ... of paper unless you can do zero. But are you saying something different? Are you saying that there's a different ...?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I was just reacting to there has to be an exclusion for folks who just don't have any trading partners that are equipped, and I guess the only way you can do that is by attestation. And probably a way to at least qualify that is by zip code, we talked about this before, and you can almost know ....

W
And today the way the systems are implemented, back to your point, if we think broadly I can generate this transaction and if there's a receiving EHR, which is the big concern, will there be one, you can inbound it and store it. But if not it can go to a secure place and it can actually print it out because it's structured so I can actually read it. The summary of care record, you can either read or you can inbound it and translate it. So there's a lot of flexibility. I would want to count, if I sent it there and they could only print it out and read the electronic—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
...

W
I think that's better seeing it electronically and having it, even if they can't except inbound in their EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. It's almost like doing the ... electronic .... We're capturing some of these nuances and we've got to remember to make sure that we include, remember we want to have a big preamble so that we can make sure some of these questions are .... Okay, that sounds good. Then that all of a sudden eliminates probably the HIE objectives and all the attendant .., is that right? Okay. Then the longitudinal care rec plan, and I think Eva had something to say there. Everybody liked the idea and the question is do we have a standard ....

W
Can I ask a quick question, just before we get into that? There was some discussion earlier, and my question is should we have this broader discussion now or later, but a discussion earlier about we're going to eliminate the HIE requirements, think of use cases in the plural, not just transition of care records, which is really important, and I agree with that. But should we also discuss these other methods? To me it's stronger if they're having to be these other things, such as MEDREC and care plan, well, care plan we're about to discuss, anyway to also link them to electronic means. But maybe that's a different discussion for later. I'm just thinking if we're eliminating it altogether, the HIE requirement because we now have it fixed through the way we're doing transitions of care records, I would feel a little bit better if we had other things tied to exchange as well. And I'm not trying to undo anything we've done, I'm just asking should we have a conversation about other opportunities to tie other things to exchange? And if so, should we do that now or should we do it later?

David Lansky – Pacific Business Group on Health – President & CEO
Paul, can I make a comment? It's David.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure, David.

David Lansky – Pacific Business Group on Health – President & CEO
One point, in the IE Workgroup discussion we pulled out a list of seven or so functions of this kind that Eva was suggesting, and maybe it's worth, maybe that's a preamble in order to address the general interest in seeing exchange be supported now that we're taking out an explicit reference to it. It's implicit in six or seven other functions to enumerate those six or seven other things and, as Eva said, talk specifically about to what degree we are distinguishing electronic transmission as opposed to any transmission. And that maybe there's a table or something we could include in the preamble that would summarize all the exchange functions that we are embedding in other specific criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so I think I'm understanding your suggestion as let's just call out what we're already doing and how it applies to HIE, because that is the main focus of stage two in the preamble. Is that it, Eva?

Eva Powell – National Partnership for Women & Families – Director IT
I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good approach.

Judy Murphy – Aurora Health Care – Vice President of Applications
Just one other comment, I'm feeling like we're maybe losing that bidirectional piece, because a lot of what we talked about, when I think about the HIE things we've already talked about and we'd have to go one by one, it's the outbound and not really accounting for the inbound yet. I can't remember all the criteria coming down.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We have lab inbound. Part of it is how much can you push the source? How much can you impose on the recipient and hold their money at bay depending on the source.

Jim
And maybe that would be a nice amendment to the idea of a table or something to have on the table the inbound and the outbound current status of our requirements or expectations so that we make it a glide path that's explicit that we want to gradually populate this table to include both the outbound and the inbound. But we understand we have some limitations on our ability to pull the inbound requirement given that we don't have a lot of control over the whole universe.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, and it would also make it optically clear that, hey, it's in your best interest to get this thing going bidirectionally, even though we're addressing it in a piecemeal fashion.

W
Because an interesting use case is when a patient is admitted into the hospital that the EP would send a summary of care document and it's not one we've actually called out much.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

W
As just one example, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Okay, ...?

Eva Powell – National Partnership for Women & Families – Director IT
Thanks. What I did, and this is my rough document that I put together yesterday ..., the issues regarding longitudinal care plan, the main issues have been a definition of what that is, and then are there

standards. What I tried to do is go through a lot of the work that has been done to see what do we have and what can we build upon to get something related to care planning in stage two that's also reasonable for our time frame. I started with accepted practices because some of the arguments that I've heard from providers is that this should not be determined by a regulation. This should be a consensus based definition. Well, it is. NQF has put together definitions as part of care coordination recently endorsed care practices, and they've got measures in here as well, but the care practices I think are more useful for our purpose.

I went through the NQF document and basically took their definition, which includes specific elements of a care plan, and some of their elements still need some definition. So that's where I've taken some liberties that we can discuss today and then also mapped those two things that we already have in meaningful use or are included in the proposed meaningful use criteria. I won't read through all of this, but basically I'll start with the elements of a care plan according to the NQF endorsed preferred practices or diagnosis or problem, and we already have that in meaningful use. It also matches up with the CCR, CCD chart that Josh sent yesterday. Then there are environmental and social factors that contribute to the problem, we don't yet have that in meaningful use, but that is part of the CCR, CCD standard, so we do have a standard for that.

Other known factors, and other known factors need some definition. In looking through what's in CCD and CCR, and those of you who know more than I do about CCD and CCR please correct me if I'm misinterpreting something. But health status assessments were part of CCD and CCR and in my mind that could be part of a more specific definition of other known factors, which also gets some important information coming from the patient.

Plan of care, that's not clearly defined in the NQF document, but in the other succeeding practices add to a definition there because they talk about things such as patient goals and other things that you would have to have as part of a care plan in order to include them in practice later on. So as part of the work that the CPEH has done, we've identified the goals of treatment, the clinical goals, and patient goals such as I want to live independently, something like that, then actions to be taken and a timeline along with the responsible party. The responsible party matches up to what our current recommendation is for stage two meaningful use care team members, and may actually be a way to get at the problem with that in terms of identifying and putting parameters around care team members. If you have a role in the care plan then you're a member of the care team, so that's some of my thinking there.

Then surrogate decision maker is not yet anywhere. Appointments for follow up is already part of meaningful use, or at least the criteria of a discharge instruction. Self-management training and skills, that's broader than what is currently in meaningful use but we can build on what's currently in meaningful use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Where did you think that that was covered?

Eva Powell – National Partnership for Women & Families – Director IT
Let's see, I think that from the discharge instructions criteria, including pieces that could be built upon for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which element were you talking about?

Eva Powell – National Partnership for Women & Families – Director IT
I'm sorry?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which element were you talking about?

Eva Powell – National Partnership for Women & Families – Director IT

The self-management training and skills identified by patients. That's broader than what's in meaningful use, but the discharge instructions include condition, meds, activities, and diet, follow up appointments, referrals, scheduled tests. Some of those things could be built upon for some self-management. Perhaps the activities and diet I think is where I was making the link. Then participation level, level of engagement, that's not in meaningful use but there's a CCD, CCR piece component to that, as well as advanced directives and listing meds are obviously also already in meaningful use. I'll stop there for any comments or thoughts, or would it be more helpful for me to—the other thing I did on this document is to go through, again, this is going back to the NQF endorsed practices of how do you use a care plan. There's much supported by meaningful use already there, but I thought that might be important for us to define exactly what part of care planning should be under meaningful use in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I appreciate that, Eva. I wonder if there is a minimum data set that—I like your idea that hey, it's already here. Some of these you took a little ... because maybe there is stuff that's already there that if we could aggregate in a "recorder" document and get it to go places. That's our first step on the way to stage three, something more robust, because hopefully things like ACO kinds of concepts will make this more obvious to everybody that they need to have this stuff moved around. So is there a minimum data set, so for example, clearly the diagnosis of the problem, the responsible party, that's the whole care team, the AD, the advanced directives, the meds are one there and would be part of a longitudinal document. If we try not to stretch to what isn't already there, do you think that would work?

Eva Powell – National Partnership for Women & Families – Director IT
I think so. I think another thing to consider, though, is how do these data elements that are very concrete and well-defined, how do they link up with other things that are already in meaningful use that are clearly related to the care plan, such as the care summary, discharge summary, and some of those other documents. Because we know other information will be in those documents that would be important for the care plan, even though we've not pulled them out discretely in our conversations.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is it possible, because we gave some examples in summary of care, we had a ... with a bunch of examples, and a lot of these are problems—

Eva Powell – National Partnership for Women & Families – Director IT
Right, right, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I'm wondering if this is a good placeholder for stage two instead of a different document. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I think that this is, in a sense, we should try to think about how to incorporate this into the same concept as the visit summary, because the more different kinds of documents that we have, the more confusing it's going to get for providers and patients, so most of this is in the care summary. If there are pieces that aren't we can put them there so that we don't end up with another type of document. But one of the purposes we keep talking about of the care summary is so a patient can have access to it and know what they're supposed to do next. Some of the same rationale that we're talking about is the same rationale we use when we talked about the care summary. I think we should try to figure out what piece of share we might want to add in to the care summary and end up with one single document rather than say that we need a separate type of document.

The second point I want to make is that the term "longitudinal" confuses me. I don't know whether it confuses anybody else. But to me it sounds like that you're accumulating information over time and when I think of a longitudinal record I think show me all the medications somebody was on three years ago and all the changes in medications that have gone on over three years, so that word confuses me. Maybe we should just call it a care summary and take out the word "longitudinal." Then if we call it a care summary it very much is like the care summary that we have and some of these elements are. I think it's brilliant to

pull out the stuff that we've already done because a lot of it is there and what I think we're talking about is organizing it in a way that's accessible to patients and a way that is usable to other providers.

Eva Powell – National Partnership for Women & Families – Director IT
I think that's good. I think also your point about longitudinal as well as about incorporating it into one document I think is good when we're thinking further down the road. And thinking about, at least in my mind and as we've talked in the coalition about this, really what we would hope to have at some point in the future is a care document, a continuity care document. That is the medical record, and that incorporates the longitudinal piece, it incorporates the planning piece, everyone has access to it that needs access to it, and so I think longitudinally far down the road we're thinking one document. So it's a question of can we get those specific elements that point to the direction of planning, and not just planning on the part of the provider and then it's handed to the patient, the key element of this is that bidirectional involvement of patient and family in creating the plan. So that's a critical piece to have part of this.

M
Just to point out, the NCQA medical home requirement is that you have a document that's part of the NCQA medical home requirement. So there's a perfect connection there and a lot of us ... these kinds of things into our patient instructions now, not instructions, but our documentation of patient preferences and things like that. So I think that it's definitely part of what people are going to be doing more and more of.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So am I hearing some movement towards, instead of creating yet another document with yet another ... to be defined definition, to move and to make sure that we have a robust summary of care document that can flow with the patient? Okay, a lot of nods here.

Eva Powell – National Partnership for Women & Families – Director IT
I think so, but I guess I don't want to lose, first of all, the planning component of that, because a summary of care does not necessarily include a plan. And I don't want to lose the engagement of the patient component of that either, and a summary of care does not involve patient input. So I'm not sure I'm all for having one document. I'm not sure how to achieve that and achieve those other things as well given what I know the typical process is now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And I know that you know that I'm very supportive of that. I think what we need to do is first get something to move around and because the community is not aware of even what constitutes that. This whole notion of I think over the next even few years we will be, I think all of us will be much more sensitive to the needs of this partnership with patients and this shared plan really, this shared document, shared plan that this whole electronic movement and the access will create some of that. But hopefully the delivery model of the future will also be much more, that will be much integral to those models. I'm wondering if we start thinking about stage three and setting up some of the standards activity towards going there, we could benefit that on the professional side, ... consumers, etc., but it's a little premature for meaningful use to all of a sudden dictate something that's not been vetted out. Does that make sense?

Eva Powell – National Partnership for Women & Families – Director IT
Yes, I think it does. I think one of the things to consider before we just ... into the summary of care document, as the summary of care document has currently been discussed, is to think also about how current processes could, without too much burden, knit into this in stage two. And I've had some discussion with some hospital based folks, and what I've learned from those conversations is that at least for planned admissions we've got the pieces there. In other words, for a HIPAA placement it's very common to have an order set and the pre-admission care, which contains some self-care stuff in terms of NPO and whatever exercises perhaps they need to do, and then on the back end there's the discharge instructions that include some self-care, ... So why can we not tie those things together as part of a care plan, because those things are already being done and that gets at more the planning.

I think it is a good step to identify, as you described, the minimum data set. I'm not sure that's good enough in stage two to do that alone. I would like to see taking some of what we know already happens in provider settings and taking that a step further, utilizing some of the things that we already have in meaningful use to put together an actual care plan. I think particularly in a hospital setting for planned admissions, where the pieces and parts are being done but they're being done in isolation of themselves, making those things longitudinal, being hooked together, requiring people to think longitudinally is absolutely something that can happen in stage two.

M
... two questions. One is that we rename the first document and we call it a summary and care plan, so that it really calls out the fact that it's not just a summary of what's gone on. And second, that we look for the elements that are missing from the current summary that we'd want to include but that are present in parts of the electronic health record. So for example, when we order diagnostic tests, those are ordered electronically and they can be put right into the care summary as these are the things that are happening. When we order medications those can be put in the care summary. Then there are educational pieces that a lot of electronic health records have access to, and those can be put in the care summary.

Then finally, and I don't know enough about this because other people did this in my shop. But we should look at what that NCQA requirement is for a shared care plan and see if we can't figure out a way to put that into the summary as well, so that what we're doing is we're building a care summary and plan as a single document. Because really if you think about it, who would want a summary of what went on without also knowing what they're supposed to be doing in the future. So I think we should look at the pieces that are missing and revisit that. I think to the extent that those things are in stage two already we should put them in in stage two and just use that as a way to modify the summary and then call out the other things that aren't in stage two for stage three. For example, maybe that shared patient plan should be a stage three requirement, but the other pieces could easily be put in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so we can come up with a concept, a summary of care plan, and then have HIT Standards Committee come up with the elements. We can create our (e.g.) and have number of these things listed, as we did, but then try to have the Standards Committee weigh in on this. Okay. Yes?

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you want to ... people on the phone?

W
I'm sorry. There's a very active dialogue going on right now, including a lot of clinicians, about what the data elements should be for the transition document and how to .... I know it's not part of the protocol to do it right now, but it might be good to ... that conversation that's happening in case they could incorporate pieces of what you're talking about right now.

W
Right, and those are some of the folks I've been talking to, which is why I'm pushing this, because I know there's a lot of work already going on. We're not as far off as we seem to think that we are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, very good. I think that wraps up care coordination. Let me ask, is there eating available in this building?

W
No, there's nothing—

M

... but it's about, you can go—

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CM</u>
<u>M</u>
What's the minimum time?

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO</u>
Yes, what's the minimum time?

<u>W</u>
... eat at the table and come back in 30 minutes.

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO</u>
So it takes—

<u>W</u>
You can bring it back.

<u>M</u>
Oh yes, yes.

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO</u>
So is it possible to come back in half an hour?

<u>W</u>
....

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO</u>
Can we adjourn for half an hour and then we'll be back at 12:45 then?

(Lunch break)

<u>Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO</u>
Welcome back, and thanks for helping us out with a short lunch break and the people in the room are still eating .... Nominally, we have just a little over an hour left. We do have another call right before the HIT Policy Committee, so in order to deal with the topic that I think we'll need more preparation before preparing the presentation for the Policy Committee first, that is the timing issue, I thought we'd reverse order there. If we spill over a little bit into the call with category four I think that's easier for us to manage from a presentation point of view. If that's okay with folks, then we'll discuss the timing next.

So you'll recall that the issue is that, well, there were two camps. The providers and the vendors felt very strongly that they needed time to adjust to new requirements especially in stage two, that everything from developing new functionality through the testing and the obtaining certification, etc., and the implementation side from the provider point of view, and unfortunately those can't go on in parallel. They have to happen sequentially. So the timing could be as soon as the final rule coming out in the middle of 2012 and hospitals needing to, or they could need to start certifying and reporting in the third quarter of 2012 for stage two. So we thought of a number of options to consider and what we did is we put that before the committee and they gave us some suggestions as well.

I think at this point we want to step back and see what can we do to again still try to maintain the momentum, we still want forward progress to be made. I think more now than ever, i.e. more than what we thought about in stage one, is the pressures of ACO kinds of models, new payment mechanisms that may be in our future, and the National Quality Strategy and the things that the secretary wants to accomplish. So if anything people would want to be more aligned with where we're headed in stage three. Nevertheless, it still takes calendar time to get some of the stuff done. So that's the kind of balance we're going to try to strike. Among the things that we had, options that we had considered and

we're still open to some more, one seemed like the easiest one, which was the reporting period is scheduled to go from 90 days in stage one to a full 12 months. One option we thought about is if we scale that back, or recommended scaling that back to 90 days again, that essentially gives the provider another 9 months to do everything from implementing the training to actually putting in the use. Another option is to just move the whole program, shifted by some number of months and probably logistically the only number of months that makes sense is 12, because I don't think you can cut in the middle of a fiscal and calendar year. So that's pushed back one year for stage two. We had the in between option that we thought about before, which was to come up with a 2A and 2B, and 2A is basically changing the threshold of existing functionality, and what we're buying there is not having to re-certify products for a new set of functionality. Now, unfortunately they still would have to be certified for new quality measures, so there is some of that. Then 2B, which are all of our color coding the blue things, the new things, the things that weren't there in stage one.

As we've gone through so far, minus category four we've had a modest amount of increase in the functionality, i.e. the blue requirements, the new blue objectives. So I don't know if that's a fair characterization but it seemed like modest, it's not modest in effort, but in terms of number, let's say. Another possibility is, well, some of the feedback we got from the full committee, we talked about earlier today, which is once people are on the road map, on the on ramp to having the functionality and putting it in use, there's really no inherent reason why they would stop. One is it's painful to be in a hybrid situation; and two, the world now more than ever is going in the direction where you need to take full advantage of this, the rich functionality in the EHR and the data stored there. So it's not clear that changing thresholds except for the really low ones makes a difference. It seems like once people pass about 30% they start behaving as if you have to treat everybody the same, which is true.

That leaves open the option of keeping stage one requirements, which really, well, that simplifies some of the problem, and just adding the new stuff for stage two. I don't know that that may simplify some of the problems from the provider point of view. It doesn't – well, I'm not sure what that accomplishes. It's more basically a statement that changing the threshold has probably not a real significant impact on its use. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, I think that there's one more option to think about. In the current rule once you're on the road you have to execute each of the four years. The biggest issue is with the people who are attesting this year, because it means that if we don't get this all finished by mid-2012 those hospitals who said they were going to attest in 2011 have to be up and running at the stage two level by October, otherwise they lose the money for stage two. And there's just no viable way of doing that. An option might be, rather than moving back the whole program, allowing them to skip a year. And then other ones who start in 2012 and 2013 might not skip a year and they can just keep going. So if there was an option to skip a year, it doesn't move everybody back, but it would move at least the ones that are in trouble, the very near term ones, as a possibility.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does that help the vendors in the development cycle as well?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Well, if we can move—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It basically gives you another year as well. Karen, is that within your—

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Drop down a year and get on to next year's – for early adopters it does give them—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
... more time, but it doesn't move your whole program back.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a really good point.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's not something that we had thought of, so I want to give that some thought and talk to counsel. I don't see any reason on the face of it why there's a huge problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Was that matrix baked into HITECH, the ...?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so that seems like it's available.

M
That is option three except that option three was ambiguous as to what you do with everybody else.
... is option three we said leave everything alone, it only affects 2011.

M
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
2011 is our —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's the problem. They're the only ones that have to be in 2012 —

M
... in stage two by October 2012.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's the problem, for hospitals it's October 2012, right?

M
For hospitals, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And then physicians in January, so it's only six months. There's not much time there either.

M
That's a really nice—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... flexibility to drop down a year.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
... drop down the matrix.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Really good, and then also there's no penalties.

M
And the third year is ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And you don't get paid when you drop.

M
... three. That three is—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... dropped out a year.

M
Option three says delay the transition to stage two, it doesn't say how. This is one way to delay. The other way would have been to give everybody three years in stage one. But we didn't say either way what we meant by it, so what ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is a compromise. It doesn't delay the program. It only affects one group, the group that comes in in 2011, and because of the way the rule's written those people would be subject to a loss of one year's incentive.

M
That's a huge problem.

(Participants speaking simultaneously)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's the difference. The difference is you're not going to pay them for a year, whereas, this would have paid them for that year.

M
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Got it. Now I understand. Thank you.

Farzad Mostashari – ONC – National Coordinator
But under the current situation if they can't make it in three or six months they lose that payment year period, forever, they lose that money.

M
So give them the option.

W
I was going to say—

M
Let them go if they're ready. Let them delay if they want to delay.

M
But ...—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But ... an option because then the vendors have to do it—

M
We want the vendors to do it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But it's a feasibility—

M
But the key fact is—

M
... the concept is that they can't do us.

M
Everyone has to be ... at the beginning of the year. Even if you're in stage one your product has to be stage two. That's what we clarified a week or two ago. It means the vendors have to be, as long as some person has to be in stage two by 2013, all the products have to be ready by then.

M
It does help the vendors. It helps the vendors in two ways. First of all, it doesn't help them with getting their product certified, but it helps them in one of the things that Charlene keeps mentioning is that I have to move my entire—

M
No, but that's what we clarified, they still have to move the whole installed base to stage two even though they're only—

M
.. stage one.

W
Was that in the rules?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know. Can we restate this? I didn't interpret—

M
I haven't heard ... yet.

W
That was Steve's email, I think.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that, if I'm following this, I think that one of the things that has come up repeatedly is this issue of having to do implementations for all of your providers at basically the same time. And part of what you're saying is that this would potentially give, you'd have some people who would be ready to go maybe right away, and then you'd have others who would take an extra year if they were 2011 implementers.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The problem with the 2011 implementers, because we just don't have time, we need time, just like CMS needs time, to develop this process. We won't know until this final rule is done and we'll get the specs and then we'll develop the software and we'll go through certification and we'll test it, and then we've got to roll it out across our customers. So that time you need really 18 months to do that effectively. Now

we'll get the signal from the market, but you need a pretty robust window in there to be able to deliver the certified stage two product to the customer base.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's clarify the e-mail from ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's a different issue.

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the first customers that go live in 2011, by 2013 they have to have stage two and the statement is that all the vendors' products must be certified that year and certified that year according to stage two. Is that the statement, and that's consistent with Steve's message?

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We had committed to putting out, and which we're close to being able to do, a list of the actual changes that needed to be made in the certified process so that we could scope out what the extent of those are. Then I think rather than just saying let's just delay, I think we can look at that list intelligently and say, of all of the things on this list race and ethnicity is going to take up 40% of the time. If we eliminated that we could do it, or however we look at it, but we haven't compiled, maybe you've done this as a vendor.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
As best as I can to date, until they change it on me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which we did today. So the point is, and then I think, in all fairness, we need to get a broad sense of the community of vendors what we're talking about there in terms of timeline, because I think we have to make sure it's real, that what we're doing is real and doable. So I would say that on the first hand.

The second thing is, I think it is reasonable if it's possible to delay to allow certain providers to say to the vendor I want to delay the upgrade and I'm willing to put off by a year going to phase two because I just can't handle that transition again so quickly. Then for those people I think that is a reasonable option that we should propose if it's consistent with the legislation, unless we recommended a change and it was accepted they would lose a year's pay.

M
Yes, but they're making that choice. Well, we're saying we don't want them to lose it permanently, we just want them to be able to delay it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
According to the rule, they would lose it permanently.

M
According to the —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The existing rule. Once you miss, you lose it permanently, except for Medicare.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So do you have some kind of sense of, before we make any changes today, what the level of effort required for the new things that we've proposed already?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I just have quantitative issues, and again, can they support it today? I'm going to be honest, the bulk of most of the ... except longitudinal care plan, and again this is with the caveat we don't know what the new standards are going to put in there. We got a lot of pushback on the race and ethnicity one, and again, it transcends into registration system and all that. So it just gets to be a really—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... so concern on that one. The longitudinal care plan, there's concern just because it's undefined, the standards aren't there and there's a lot of ambiguity about what .... The rest of them, most providers, as best they can interpret most vendors support, to some extent, today, they support secure messaging and those kinds of things. Physician notes in hospitals is a problem, although most people feel they can do it, but in general where the bar was set there were, I would say, 70%, 75% yeses and a few nos when I asked.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that sounds more feasible than I originally thought.

W
Quality measures, though.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We haven't really been dealing with that, and I can't ..., I'm guessing.

W
... quality measures and ... usability ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When you said 18 months, did you want the vendors to have all that 18 months, or did any of it go toward the deployment side?

W
That includes the deployment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so what's just the vendor side?

W
There's a number for .... I have to look at that. I've got it in the ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's say that maybe a minimum of six months and so let's say a year.

Judy Murphy – Aurora Health Care – Vice President of Applications
Creating the new feature function there's them having to go get certified, there's packaging it up so it can be downloaded by a client, the client has to download it and put it into production, get the acceptable adoption levels, which again don't look like they're going to be horrendous, and then they would be able to attest. There's that sequence of events.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But when you add all of that together it could be 18 months.

Judy Murphy – Aurora Health Care – Vice President of Applications
That sounds a little high to me, if we were really pushing ourselves, but that would be the worst case scenario. I'm thinking a year to 18 months is —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the statements is it's greater than nine months. Because one of our ... could we just, actually that nine months was only for the provider side, so one possibility is to do this waiver for this select group of really adopters, it's the 2011 attesters, to give them a waiver and with or without loss of added incentive, it would be your third payment year. Then shortening the reporting period to 90 days to give providers that extra nine months to get it through the whole process, which starts by taking in the upgrade building, etc., all the way through the implementation and use.

M
Paul, what are we going to do if the providers who are on certified products, if the vendor can't support their move to phase two. Meaning not necessarily that they're not certified, but just that they can't support the implementation, the installation, the upgrade for their entire installed user base and a provider sitting there going I'm going to lose all my money if you guys don't do "x." We're putting an incentive out there, I'm just thinking back to your comment about all the things we're calling out, what if the other side can't come back, well, here's the big thing we're calling out, we're basically saying to the providers you have to do this, but we're not really what happens if the vendors fail them. And that seems so unfair that the provider would end up being penalized in that situation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's fair. And the vendor could not be there even anymore.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could be worse than that. So I suppose that's not a responsibility of the federal government, but have you gotten questions about this, Karen? I don't know how you can answer.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
We're hearing an awful lot of concern, and it's not just from hospitals. It's from eligible professionals as well. And it's not just from the early implementers, it's from everybody.

W
About the timeline or about the ...?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What if the vendor –

(Parties speaking simultaneously)

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I think that's part of it. I think the concern about vendor support is driven by the timeline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I just had a comment on the section that Eva was talking about. It does say you're supposed to be using stage two technology. That doesn't mean they couldn't change their mind, but that is what it says.

W
... that's in the rule ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's in the permanent certification program, the final rule.

W
As it stands today I think ... reporting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're saying that they can stay on their initially certified product for stage one as long as stage one payments are ... stage one?

M
No.

W
That's the issue.

M
Yes, it's because of—

W
We do not .... if we're going to convert to it overnight.

M
Just because it's on a yearly schedule as opposed to what meaningful use—

W
It's not even doable.

M
So ... one payment year in the beginning of 2013 you'll have to get on stage two certifications to certify the product.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that means that only if you are qualifying under stage one you will have to go to—

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... you will have to go to the upgrade.

M
Yes.

W
....

Steve Posnack – ONC – Policy Analyst
Steve Posnack is now on the line.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, Steve. I'm reading his e-mail actually, but go ahead. .... Steve, do you understand the questions that we have, or the confusion that we have?

M
He's coming.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
He said he's on the line. Steve, are you here?

M
... on mute.

M
He might be on mute. Maybe he is .... But that is a good way .... Now if you decide to join in 2012 when year two starts to ... is not out yet, you can do stage one certified criteria. But the minute you move to the next year in 2013, despite the meaningful use stage you have to be on the updated product.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's requiring major upgrades every year.

W
When you don't even really need them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When you don't need them.

W
That has to be fixed.

W
That's the ... sent that e-mail and that's ....

(Parties speaking simultaneously)

M
.. rule, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so those are two different things.

W
We should separate them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We should separate them. Are there any other creative options for how to minimally change, we can't change the statute, but we can make recommendations to alter the rule. What other things can have the least amount of impact on the overall program?

M
I still think option three, where maybe you don't do option two anymore and you just do option three, where what you do is everywhere in 2013 instead of stage two you say stage one, then change nothing else in the program other than that. That gives the vendors a year. It means that the certification is pushed back a year. The upgrade is pushed back a year. And it's equivalent to option four.

M
... stage three? Now you've shortened that—

W
....

M
... one year, can we do this once?

M
Yes.

W
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's equivalent to option four in the sense that number two on the four is the real stage two and number one under option four is the updated stage one, where we just say we don't want to be playing around with the threshold anyway. So what was formerly stage one prime, which is going to be an upping of the thresholds anyway, and now we're saying we don't really want to up the threshold as much as we thought we did based on the Policy Committee meeting, so stage one prime becomes close to stage one. So it would be a way of doing this.

M
Yes, there's a cost of making it complex.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, that's what I'm saying. I'm saying stage three eliminates all other options. ... 2013 stage two you put a one and you're done.

Judy Murphy – Aurora Health Care – Vice President of Applications
George, the one really big advantage to using that option is, and Charlene leaned over and said it to me and I was thinking the same thing, you're going to get a lot of people going into an '11 then.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
....

Judy Murphy – Aurora Health Care – Vice President of Applications
No, but the point is now we're incenting people to go early because they'll get to stay at stage one for a while. Right now people are sitting back because they don't understand this timing thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But that's a good thing.

Judy Murphy – Aurora Health Care – Vice President of Applications
I'm just saying —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what you call a two-fer.

(Parties speaking simultaneously)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's going to be $4,000.

W
... in stage two.

Judy Murphy – Aurora Health Care – Vice President of Applications
You have to eventually.

M
Why?

M
To pick up the ....

Judy Murphy – Aurora Health Care – Vice President of Applications
... payment.

M
Big deal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You have to —

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... so I'm not worried about the hospital —

M
... four months into stages for 2011, though.

M
It only rewards the 2011 folks.

M
Yes.

Judy Murphy – Aurora Health Care – Vice President of Applications
But ... people going sooner rather than later.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Steve, do you want to help us un-confuse ourselves about certification ....? And the other thing is, and what latitude do you think we have in terms of making recommendations?

Steve Posnack – ONC – Policy Analyst
Sure. Is this mic on? The benefit of this meeting is being at Switzer today, ... run over from Humphrey. I heard at least the tail end of the conversation when I sent Josh an e-mail that I was running over. The policy that's expressed in the permanent certification program is that regardless of the stage at which someone's entering meaningful use. The product that they are required to have in order to meet the definition of certified EHR technology is something that's certified through the most current certification criteria that we've adopted, so that everyone's using technology that meets the same set of certification criteria, the same level of interoperability, the same vocabulary standards, etc. What they have to do to demonstrate meaningful use of that technology could be different depending on the stage at which they're trying to get the incentive. So if they're going to be a stage one user, they have to do less than a stage two user, but the policy principle that we've expressed is that the technology that they have should be the same.

M
When you receive comments about that with forced upgrades, which are major activities, how did you take that into account?

Steve Posnack – ONC – Policy Analyst
We balance that with our interoperability policy and the fact that it's an incentive program among other considerations. But I'm paraphrasing a lot of the policy discussions that we included in the rule and our NPRM. The proposal that we put out in March of last year really went into a great amount of detail about the transition period and how the stage is and that it could create these situations where, I think as the proposed rule had, you went from stage one to two to three over the course of three years, boom, boom, boom. And in some of those cases it actually benefited those providers to have technology that was already stage two ready because they have to transition in the middle of a rule making. Because if we're doing two year rule making cycles or rule making that accounts for two years, there could be a transition period right in the middle where they'll need to demonstrate the next stage of meaningful use. But if we allow them to just have the technology for the prior stage, they have to upgrade anyway. So we saw that in some cases as a prospective benefit to them, that they have technology already ready, they just don't need to demonstrate meaningful use yet for some of those capabilities.

M
Although they'd have to re-implement it the following year when they were going to the next stage anyway because you have to get certified by year, right?

Steve Posnack – ONC – Policy Analyst
Our certification currently is applicable to 2011-2012. It's a set time period for the criteria that we've adopted pending the two year rule making .... Obviously, a lot of the things that you all are wrestling with in terms of timing in both the depth and breadth of stage one and stage two recommendations could have an influence on what we do in terms of overall flexibility in terms of what you recommend. Everything's on the table to recommend, I think that's what we're here for, to hear your recommendations. Like Karen was saying when I ducked out of my office, we have heard a lot of concerns about timing and the on-the-ground implementation about how long it takes to do some of these things. That's the ... of that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's talk about George's suggestion a little bit more. That was the replace stage two in 2013 with stage one. Is that it?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes. I'm not sure what I'm voting for, but that's —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, we're not voting yet. We're just trying to understand it. One of the implications, it does give vendors and providers an extra year even without the 90 days, shortening it to 9 days, and one of the implications is that it does reward the 2011 only with an extra year of payment, which is one of the bigger years of payment, by staying in stage one. There's a good chance that folks that are qualifying early are going to go to stage three anyway. That's why they do these things. What other downsides are there? It does put pressure on stage three a lot.

Steve Posnack – ONC – Policy Analyst
Obviously there are carrots and the sticks. It may preclude there being any carrots for stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Before the stick comes down.

W
It also doesn't move things forward in terms of advancing some of the major goals of the National Quality Strategy and ACOs, because much of what's required by those two things and much of the primary goals of those are things that really aren't very prevalent in stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And that's true, but actually that's been part of our tether in the sense that we can't move the market faster than it can go ....

W
Right, but could we prioritize? What I'm wondering is, because I've always gravitated toward option four, but modified slightly to reflect in 2013 not just the stage one requirements that might have some tweaks to them, but also some prioritized new requirements that are absolutely essential. Because I just don't see how if no vendor on the planet can do health information exchange and care coordination and care planning, how is that ever going to get off the ground, how in the timeline that we've got? We're already behind according to the other federal programs in terms of technology supporting those programs and so if we delay things by yet another year we're going to have federal programs that are critical to health reform with little to no support through HIT. And how can we consider that doing our job?

I'm wondering if a better approach may be to look either at what George is saying or the option four and not put all new objectives in one year, but look at prioritizing what new objectives really are the most critical ones to get going on now and have those in 2013. That way vendors and providers can focus their energy on a smaller set of new criteria but we're not foregoing them altogether. But we're also giving them a break because again it's not the broad set of new criteria, it's the more focused set. I just really worry about leaving care coordination, health information exchange, all of those things, by virtue of what we've just described, would not happen until 2014.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's not the answer, but a portfolio. One worry, though, I have is that if we put new things in '13 and then some new things in '14, and there will be new things in '15 for stage three, that's upgrading your system three years in a row.

M
Yes, that's—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's the downside there.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
One other factor as we look at this, and we should put this on our timeline, 2013, given the current timelines, is when there's a major upgrade to ICD-10. That's really important. I support getting there because it's going to be important for measurement and a lot of purposes, even though we may want a different basis for our ... the Quality Workgroup's discussion. So that's a consideration here.

Again, from the vendor communities' perspective there's been a lot of software that's been delivered in this last year, and so there would be support for near term approach if it was just raising those thresholds and not having to go through certification.   I think that chart was ..., here's your list of functions, here's what you've got now, green, and we can all go and you can just raise your thresholds. And then here's where there's some development, I think will be an important one to look at, because then you can make some of those tradeoffs. As soon as you add that new function in, and we've even got new requirements within some of the current requirements, then you go back to certification and you have to re-deliver it to the customer and those types of things. HIE is embedded in products as it's rolled out today. It's just not turned on. So it seems like some of those things, we've got enabled in products the ability to be able to test to be able to exchange a document. We can execute that, it would strike me, in stage two, because the software's there. We've got the orders that are ... for lab and radiology, that's there today.

M
So you said 2013 is ICD-10, wouldn't you argue to want it make it in one upgrade?

W

I would.

M
So in some sense that would argue for having the upgrade in 2013.

W
And moving that year, yes.

M
And they're going to want to have that before October 1.

W
It's the timing such that because they have to have it before October 1 but the regs won't be known until June, so there's just not enough time.

M
I'm talking about October 1, 2013 for IT. So they have to have it sometime way before October 1, 2013, let's say it's January, it's winter, so ideally we would try to give vendors enough notice that they could have the same functionality. And many are on the way anyway, to have that in that same release, because we all as providers only want to do that one major release. So one choice we can give CMS is either we, as Eva said, we prioritize and pick the most important ones and go ahead with 2013 full speed ahead with a smaller set of things that are feasible, which would map with ICD-9. Or we keep it as stringent as it is today—it's 10, thank you—or we keep it as stringent as it is today and push it back a year to 2014. That would make it easier and earlier or harder and later.

W
ICD-10 aligns—

M
With which one, doing it in 2013?

(Parties speaking simultaneously)

W
ICD-10 is October of 2013, which is fiscal year 2014.

W
Right.

M
It aligns with option four, sub two.

M
Oh, okay.

Farzad Mostashari – ONC – National Coordinator
But interestingly, option four, I think George pointed out, is the same as what George was talking about, meaning skip 13.

M
In effect option four sub 1, if you focus on that one, it serves as a transition year essentially. So even for folks that started in 2011 they would still have to demonstrate more meaningful use, because right now they have to do 80% essentially of the objectives and measures, they would have to do 100% of the objectives and measures that they currently only have to do 80% for in order to keep their .... No new functionality would be required, so certification will remain the same, and then by October 1, 2013 that's

when fiscal year '14 for hospitals, as Karen mentioned, will start, and they would need to have ICD-10 in place already.

M
Here's a different proposal for one prime, what if instead of upping the threshold in one prime we just make the menus that we're going to make core, core. And that's the change that occurred in 2013, so no new certification, no new product, but it's important things that are getting done instead of tweaking thresholds and then '14 is the new new stuff.

M
I assume that's what Steve meant by the 80%, right?

M
It —

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think there are two policy decisions that George is touching on. One is, ... is 30% right now for stage one 2013. For stage one prime is it still 30%, or do you raise it to 40%? So that's policy decision one, bucket that. The second bucket is moving things that are currently menu to core without any measurement change.

M
That makes more sense and I interpreted that as your 80 is going to 100. That's what I was reading into the e.g. there.

M
Any e.g. you can have an and/or, move menu set to core and/or increase the threshold ....

M
So what are we doing with all the new stuff that we've spent the last six months talking about?

M
Where?

M
It's still there in stage two which appears in 2014.

M
When do we do stage three, in 2015?

M
Yes.

M
And so we're going to put out another interim final rule, do the final thing, certification and all of that stuff in a 12 month period —

M
Whatever, we'll deal with that then.

W
It's the same problem then ... now.

M
No, it's not the same problem because now we have two year intervals.

M
One at a time.

W
... to be defined in the final rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Steve has to ....

Steve Posnack – ONC – Policy Analyst
This is Steve. We've kind of ... along the way that we'd be on a two year cycle for rulemaking, so in this case if you're discussing the prime and moving stage two to 2014 it would kind of extend, we've talked about this, and slope as well. It would shorten the rise and run in 2013 but make it a steeper rise and run between 2013 and 2014 and continue the same slope that the escalator's been on. And then the next rulemaking, which I don't know if all of you are still here on ... at the end of 2013 and into 2014, you would be discussing revisiting what you've been discussing in stage three for the rule making that would take place for the 2015-2016 years. As Josh mentioned, that would implicate the downward payment adjustments because you'd extend it through the incentives at that point—

M
It's interesting ....

Steve Posnack – ONC – Policy Analyst
... depending on measures ....

M
It's interesting that stage three could happen in 2016 and have almost the same oomph because the payment is so low in the fifth year and yet it still would be on the escalator to trying to reform the whole system.

Judy Murphy – Aurora Health Care – Vice President of Applications
I ... remember, this is Judy, how many years each hospital can qualify. I was actually trying to find that grid, because if you start at the core, that's where—

W
No, no, hospital—

Judy Murphy – Aurora Health Care – Vice President of Applications
Hospital core, so if we go stage one, stage one, sort of Stage, what did we call it, stage one prime, stage two, there is no three, four people that go in '11. And I was just having that aha myself, right?

Steve Posnack – ONC – Policy Analyst
There wouldn't be an incentive stage for them.

W
....

Judy Murphy – Aurora Health Care – Vice President of Applications
Right, it would be for the other folks.

W
Right. No, they would still have to meet the stage three requirements.

M
They wouldn't avoid those—

W
Oh, ...

M
The financial incentive to get with the program is always going to be there, and maybe this is one of the ways to balance—we can't crunch everybody, it's very painful to do a major upgrade every year for three years in a row. It's just very hard. And we want people to survive this and be better off for it, but we don't have experience yet with what happened in 2012 and we can't. Therefore, our only option is to offer options at this point, and one option is to do what we've worked hard on in 2013, and that's one option that CMS will have. We've done all this work, people are far ahead, it's working pretty well, better than we're thinking right now, and we go ahead with 2013.

Another option is this pair of two different choices to slow it down. It's going ahead because it's going really fast or two options to slow it down, and CMS is going to slow it down anyway if they need to, regardless of what we recommend, so what we want to do is help them prioritize if they're going to drop something what should we drop. Getting back to Eva's point, what's the main things you need to accomplish.

David Lansky – Pacific Business Group on Health – President & CEO
Can I get in?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Next week we're going to go through all this stuff including timing, all the criteria including timing, and we'll get more input and our final recommendations get approved in June. Then CMS has six months to prepare their NPRM, at least from the last go round, and another six months to ... the final. So they have another year's worth of input ....

M
From my perspective I think we need some different frames to look at this and it includes understanding which of the things that we're calling out require approximately how much work on the part of the vendors. We can make an assessment from the provider point of view, I think, in terms of how much work that requires on the provider side to do this. Then I think whether we call it prioritization or ranking or whatever we do, we should send some signals that basically say here's our list of what we'd like to have done but we need to look at what the reality of those issues are. But I'm just speaking for myself, I would not be in favor of just slowing down the entire thing and saying let's put it off a year.

I think that there's a lot of movement in the system, we've created a lot of momentum, there's been a lot of work done, but there are a lot of people waiting for some of these things to happen. I think that we should pick out the things that we think are critically important to move forward, which we have the recs out there, we've got the people working on exchanges, and they're waiting for these signals to understand exactly what they should be focusing their energies on. And if we just wait and then think this rapid upslope is going to work three years from now, we're all going to be sitting around the table, I think we're just trading off a future problem for a present problem. I think we need a better sense of what this whole scope of activity looks like.

Eva Powell – National Partnership for Women & Families – Director IT
That's exactly what I was thinking. This is Eva. It would help, I think, to know what most systems already have that's just not being used. We've already heard two things, information exchange and I've heard patient messaging also as part of a lot of systems that just aren't being used.

W
Or it's—

M
Drug-drug interactions.

W
Yes.

Eva Powell – National Partnership for Women & Families – Director IT
And so I suspect that it would be helpful to know what truly would require recertification and upgrades. It sounds like most of what we've talked about we can do in some fashion without that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But there aren't any certification rules around all these new functions, so the fact that it's—

Eva Powell – National Partnership for Women & Families – Director IT
... they can do it. They just haven't been certified.

W
Unless—

Eva Powell – National Partnership for Women & Families – Director IT
And then put those things on the fast track for certification. I'm with Neil, there's so much here that we've worked on that benefits not only providers but patients and we cannot put that off for a year. If we need to prioritize because of the realities of the market or what have you, then let's do that. But I'm really loath to say, well, let's just continue stage one. That doesn't benefit anyone. We lose momentum. Providers are waiting for some of these things, as Neil said, so that they can get their benefit out of this, and what are we doing to the program if we make them wait yet another year to see some of the true benefit that they've been waiting for?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the medical home criteria, the new NCQA medical home criteria requires some of the functionalities that we're calling out here in terms of visit summaries and other things like that. And we're going to put that stuff off. There are other parts of this whole reform process that's going on that we're going to end up being an anchor and a drag on instead of leading, and I just think we need the information. On the other hand, we've got to do something that's real, so I think we're all smart enough to be able to sit around the table and figure that out. But the way that we currently have the information, it's very hard to really get a feel for what are the certification pieces, what are the training pieces, what are the other things that we need to do to make these decisions?

David Lansky – Pacific Business Group on Health – President & CEO
Paul, it's David. Can I get in?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, please, David.

David Lansky – Pacific Business Group on Health – President & CEO
I am endorsing both Neil and Eva's point, though I want to add that I think this conversation has taken us into the certification area. It does sound like we should be thinking about stage three and making sure that any functionality we anticipate needed for stage three is articulated now so that the vendor certification process over the next couple of years puts in place as much of that as possible so there is a technology re-working before 2015. Because mostly what we're talking about isn't rocket science, it's stuff that's in some products but not others that we would need to add to the recommendations for certification so that the stage three certification types of requirements are actually embedded in the next cycle instead of waiting for another full round. Then the issue is more about user implementation and what requirements and criteria we recommend.

The other thing I wanted to say for this discussion is that I think our focus should be on what are the policy objectives and what are the technology requirements to support them, which Eva and Neil have said really eloquently about ACOs, medical homes, and so on. The fact that there may be a technology adoption difficulty is appropriate for ONC and CMS to examine and figure out what's realistic for what

proportion of the market and in what time frame, and the fact that there may be a political discussion going on that CMS will adjudicate. But I feel that we get a little bit outside of our territory to try to anticipate the broad state of the technology process and the broad state of the political factors. That we should really make, in our comments to the Policy Committee, if we have agreement that certain functions are really important to support improved care and the larger objectives that are in the quality strategy and the reform approach, we should say these are the priority functions that are needed to support that. Then as others have said, CMS and others will make a judgment at the end of the day as to what resources are feasible, but our job should be to emphasize what the priorities are. And I think people today have said really well what some of those are.

For me personally I would not worry so much about changing thresholds and so on. I would worry about making sure that the information exchange functionality, the care coordination functionality, the patient engagement functionality, is in the products and at least minimally in the criteria as soon as possible, because all the other key parts of reform depend upon it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's well put and well summarized, David. I think like the balance we're all trying to make, representing two perspectives around this table. What if we put two options in front of CMS and ONC. One is approximately the same only we could take advantage of the 90 day reporting period, that just gives some flexibility to the providers, and keep the timeline the same. And the other is, I think it's George's, which is eliminate the change in stage two in 2013. The way he stated it was substitute all the stage two's for stage one's in 2013. That does amount to a delay and all the implications thereof, but if we put those two out and then state the rationale and the consequences, that at least gives some balance to CMS and ONC to work with. How does that feel?

W
Can you restate the second one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The second one is to essentially, George, do you want to—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's effectively number three, right. It's just a version of number three. These two options are two and three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

W
Three is only applying to early attesters from 2011.

W
... you incorporated that one prime thing in there, didn't you?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I was arguing that three is like four if you don't change one prime much. I think we're going where we don't want to go.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The choices are two and three, where three doesn't mean push the whole timeline back, just change 2013. But you could also leave it, I don't see why we wouldn't leave the number one as an option depending on how well it goes. Why cut ourselves out of moving—I guess because—

W
If you just went with raising thresholds on currently certified software then there's enough time. Otherwise there is not physically enough time to get from the development process through the certification process to the customers to the upgrades for adopters in 2011. The recommendation that advisers have made is don't attempt it in 2011 because of that problem. Don't attempt.

Judy Murphy – Aurora Health Care – Vice President of Applications
I will emphasize that. I can tell you from my organization we are sitting and waiting to find out what's going to be the final. We are not going to attest until we know. Because if we have to try to meet stage two with that crunch time frame we know we can't because our vendor can't, because the certification groups can't, and we'll lose a year of payments. So we're waiting to see and we're ready to attest now, by the way.

Steve Posnack – ONC – Policy Analyst
Although you will be doing an upgrade in 2013 to get your 2013 stage one money.

M
That's true.

M
As Steve just said—

Judy Murphy – Aurora Health Care – Vice President of Applications
We have to deal with that as a second ....

M
Can I just ....   I guess we can't do this but I'm just asking the question to go a step further from what David Lansky just said and actually define stage three soon enough so that actually we do one certification upgrade in 2014. That covers, do you know what I'm saying, not do another change in 2015 but actually define it well enough so that we can actually certify in '14.

M
We actually tried that with this one because we can't start it until we have the final, which puts us in the same predicament actually. Steve and Karen?

Steve Posnack – ONC – Policy Analyst
I'll defer the mic to Karen first.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
If I don't catch your concern then please feel free, but I guess my concern about that is that we are already flying blind, to an extent, because we're looking at stage two without knowing anything about stage one really. And because the Medicare initial payments are for adopt, implement and upgrade, we know nothing about that aspect of the population at all, so to try to extend the crystal ball outwards to stage three right now I think would be really problematic in terms of we just have no clue.

Steve Posnack – ONC – Policy Analyst
Mine's going to be on a separate point, so this will be complementary. I guess I would recommend or suggest that you not take any of the options off the table in terms of just discussing and laying out the continuum for the Policy Committee at large, but maybe come up with—and I think David mentioned as well—some key factors that can be part of considerations for each of the options. So momentum and ability to meet the policy priorities, there need to be other healthcare ecosystems and things, and if you come up with probably three to five key factors that each option scores better or worse on and kind of

providing that scorecard as a bit of an .... You're not tasked to solve the problem. We're looking to you all as the experts in the field, people in the ground in various sectors to give us the best advice that you can. At the end of the day we're going to have to solve that problem juxtaposed with all policy and political priorities. So to the degree that you can give us your best guess of which option may be the sweet spot, it's going to have tradeoffs no matter what, but we think it will both give you some momentum and meet some of the policy priorities. I'm not trying to say that we look for the medium porridge here, but we'll find something that I think will equally make people mad on both sides, which will then indicate that it's a good policy.

Jessica Kahn – CMS – Project Officer
... one of the factors for consideration, this is Jess with CMS, is the operational complexity. Momentum is something that's very, very hard to articulate to providers and to people who have to actually implement this program over the next ten years. So let's think about finding the triple sweet spot, if not more, between our actual quality goals and our operational complexity and momentum and all the ... factors that we're trying to leverage that Eva and others were talking about.

Steve Posnack – ONC – Policy Analyst
Jess raises a good point, and that is, the timing issue isn't a new issue. It's been a known quantity for a long time for us and Jess can attest that we've kicked around a variety of exotic options to try to solve this problem that can get as complicated as the BCS system for football and just as controversial. But I think to Jess' point, it needs to be understandable, whatever the final outcome is, and implementable on both sides, both from us in terms of operationalizing from a program perspective, and for people that are actually going to try to achieve meaningful use. It's a real tough balance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Karen?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
My concern, what keeps me up at night is really the fact that this is a voluntary program and the people who have not jumped into the pool yet, especially the eligible professional community, is going to be looking at what we do and trying to decide whether it's even worth it. And if we end up at the end of the day without bringing a significant number of those people on board, that's not going to work either. So that's the balancing act that we've been doing with ONC and I'm not taking a position on here, but I'm saying that Steve's idea of having a construct and a scorecard is a good one, but I think that's one of the things that needs to be looked at too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think Art has—

Art Davidson – Public Health Informatics at Denver Public Health – Director
I like the idea of a scorecard. One of the things that came up during our discussion earlier was the ICD-1 issue starting in October of '13. I think if we could, as part of that scorecard, identify other factors that would drive us to one of these decisions, for me if I think about ICD-10 that number two stands out as we want to have one upgrade related to stage two of meaningful use and dealing as well with ICD-10. I know that my CIO would be very happy that he only has to go through one upgrade in that year.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil, did you have something?

Neil Calman – Institute for Family Health – President & Cofounder
No, I think—

W
... too.

Neil Calman – Institute for Family Health – President & Cofounder

Well, you permit from October 1 through the end of that year to do the measurement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so ....

M
The upgrade has to be ....

Neil Calman – Institute for Family Health – President & Cofounder
No, the upgrade has to happen by—

M
January.

W
... running at—

M
... in January, not October.

M
No, but you have to do it by October.

M
No, you have to do it by January ....

W
....

M
We can recommend otherwise.

W
We don't know how we're going to ... overnight ....

Judy Murphy – Aurora Health Care – Vice President of Applications
But your point is a good one, stage two and ICD-10.

M
Yes, yes, yes. Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Did you have another—

M
Two thoughts. One is, I'm not worried about the eligible providers being scared away because when you talk to people in the community meaningful use notwithstanding, everybody realizes they're not going to be able to practice medicine in a few years without being on an electronic health record. It's so obvious from all of the things that are being called out about data needs, what the payers are saying to us as providers, the ACO stuff, the medical home models that states are paying incentives for. There's no question that the people out there in the community, unless they're a year or two away from retirement, all realize they're going to be on electronic health records in a few years. So there's an opportunity to get in now and I think there's good evidence that people are moving in this direction. The question I wanted to ask is about Medicaid, which is on a totally different kind of timeline and whether or not somebody's sitting there lining up the Medicaid/Medicare piece as we're talking about all of these transitions and how that's going to work, because I'm totally confused by that. I know in New York State we're behind the

eight ball a little bit, and we're not even going to probably be eligible until next year, and where does that put people who are going to qualify under Medicaid and how are we coordinating those things.

W
I'll let Jess add, but as far as the eligible professionals are concerned, if you just look at the amounts of incentives, if you can qualify for both Medicaid's better.

M
If you can qualify for what?

W
If you can qualify for Medicaid—

M
No, no, I understand that. But how are the timelines going to work out when the states are all over the place in terms of when they're implementing and in terms of which certified products people are going to need to be on, what kinds and which criteria they're going to need to meet. It's really confusing.

W
...my operational complexity ....

W
People are going to think we're texting or something. That's exactly the point, because imagine how if we're going into a practice that has multiple providers, because providers are new. They come into the program, some maybe have been participating in the program since 2011, some just started in 2013, some are eligible for Medicare, some are eligible for Medicaid. They're in different stages of meaningful use, they're all using the same EHR, which hopefully is going to be upgraded to whatever Steve says it has to be by a certain time, imagine at the end of the day if somebody wants to point at that practice and say, these were the quality outcomes this program had on those providers. How are you going to quantify that? How are you going to measure, not just where they belonged accurately but really how did it transform that clinical practice? If you can't even put a finger on who belongs in which stage and in which program and trying to measure that, it becomes really challenging.

That's what we're facing right now with states, because you're right, I really think we'll have everybody up and running for adopt, implement and upgrade by the end of this calendar year, but there will be certainly delays in when they perhaps launch the rest of it. So what you're talking about is a reality that will happen, is that we'll have providers, even within the same practice, who might be staggered all over the place.

Steve Posnack – ONC – Policy Analyst
That's another factor in terms of why we went for certification on a yearly basis, because it keeps things simple, you have a 2011-2012 product. New certification criteria come out, you have the 2013-2014 product, and regardless of the provider makeup that may be part of a practice, who's eligible for what, they just know that they have a system that's certified for these two years.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, here's a proposal for how we move forward. I like the suggestion of this matrix, this score sheet, so that we can at least give you some better consensus opinion on where the tradeoffs are and those are for you to make. We won't have that by next week's presentation, but what we'll do is commit to doing that before we present a final for the committee in June. So that's a to-do for us is I think we can spend a few minutes to try to come up with some of those metrics and then we'll find a consensus way of the pluses and the minuses, just to semi-quantitate that. So we'll spend the majority of our time next week going over all of the criteria that we've gone through and walking them through that and getting their feedback and ... a bit on this timing thing and express the work plan for how to come up with a better input to the NPRM process.

How does that sound to folks? I just think that that seems like a bit of work, that this is a committee, we're supposed to have this external and diverse opinion, and we can try to weigh in on some kind of qualification as far as the tradeoff matrix. So that's a to-do for us. We will certainly need a long conversation, ... for another face-to-face before the June meeting.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The June meeting, I think it's June 11th. June 8th.

M
Are you talking about the Policy Committee meeting?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
It's June 8th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The alternative is that once we get this down pat we can circulate our opinions and then we can discuss them over the phone or a longer phone call. So let's enumerate some of these—

M
Right now the only other workgroup meeting is June 2nd.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
June 2nd we have a call? Okay, so we probably need something before June 2nd. Yes. Let's enumerate some of these attributes that you wanted to—so one was momentum. The other is meeting the programmatic needs of health reform, whether that's the ACO kinds of concepts or the National Quality Strategy. A third one we've always been talking about is the feasibility, and we could almost separate that out, the vendor feasibility and the provider feasibility. We just entered the operational complexity of the program itself from an HHS point of view. ICD-10 probably deserves its own, it's a factor, it's going to be a major factor that affects two of the major players. Other factors we should consider? I guess the financial implications to the provider.

W
That would be really good, because there are some of those things where with the rollout will be higher cost, so it will be one of the factors.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, one of the factors.

W
Three dollar signs versus two dollar signs ... mechanism.

M
Also the finances related to the meaningful use payment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I meant.

M
Oh, that's what you meant.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Other attributes?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is probably under the vendor and provider feasibility, but it would be helpful, I think to know the whys behind that. Is the crunch because we need to get things re-certified but they already exist, there's not development time there? Or is there development and certification? I think that's a huge difference that we need to know.

W
I think Josh did a chart early on which was really nice, because we used it, actually, I created it into my work sheet now, but lists the criteria, what was stage two, what's in stage three, what was in certification, that matrix? If we could build out, at least I've been using it internally and our folks took it and said, okay, this is stuff that's in the product that says that's a very valuable document that you did, but if you could update—

M
... Steve—

W
Okay, well if you could update that with the current state of these things, what's the certification and what's required new.

M
We had started to work on—

Steve Posnack – ONC – Policy Analyst
I'm getting—

W
And then we can respond to that. That would be really helpful.

M
... the current state of our ... start work on that.

W
Because the final answer's changing, so if you can get the current conclusions from today, what's in certification and then what needs to be certified, that's really helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so I'll repeat these attributes that we have and what I propose is that we'll send this around to you and before the call on the 10th look it over. I think we will have time, it's a two hour call, to even start this, and who knows we can maybe even have enough that I can present the following day. One is momentum. Another is meeting the policy needs and programmatic needs of health reform. Third is the feasibility for vendors. Fourth is the feasibility for providers, and we can break both the vendor and provider out in terms of what's driving that feasibility concern. Fifth is the operational complexity for HHS. Sixth is ICD-10 consideration and maybe that actually can go into provider, well, it's a separate thing because it affects '13.

W
It impacts standards and ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then finally it's financial implications of timing. So we'll circulate that before our call and take a look at that and actually jot down some of your ideas, because we can talk about that on the call.

M
... interdependency among the—

M
... less important but this one's critically important. You can't do without that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So interdependencies.

M
I don't think we have any criteria that you check off in a box.

W
... interdependency.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Given what Farzad said earlier, I just think we should tease out the health reform piece a little bit. There's a bunch of components. There's the quality reports, there's the prevention report that they're talking about, there's the medical home issue, the data requirements for ACOs, and I think we should—

M
If we just list them all under health reform it's going to all get lost. But I think we should ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's how to get weighting, though.

M
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can enumerate those so that people will understand how big this—

W
Yes, that's part of—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

W
Because one care coordination thing might carry the weight of 12 other things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Operationally, how do you want to proceed? We're scheduled to end about now and we can either postpone category four until our call on the 10th, or continue, I have to leave for the airport, or continue now. It looks like we have some people so let's schedule that up for the call on the 10th first thing. The second agenda item will be this matrix, and we'll present as much as we can. I think there's also some interesting CMS in providing some input on the audit process and some of the considerations that they may want for the committee to consider, because some of those affect some of the ways that objective measures are—

M
Okay, so that will be input to our call then. Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Super, great.

W
Could we also have on the agenda the second issue that we started getting into, which is the need to move to a new version of software every year?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Actually, that's part of provider so—

M
We've got to figure out how to look at provider feasibility.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, it is in there but we've got to make sure, it's just like health reform, we want to make sure that people understand all the complexities that are going on.

M
Two things?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, sir.

M
By the 11th the actual wording of what we've just done is a more complex process than it may appear to be. So there's the version that ends up on the PowerPoint slides which in some ways becomes the definitive version just because that's what you present to the Policy Committee. But then there's all the words that go in there that say actually what these things mean and so that's a process and I don't know whether we're doing that before or after the 11th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We have the 11th—

M
Oh. ... these slides have to be before ... but there's a few sentences around those short phrases, so that's something, and it usually requires a little going over. That's one thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just before I forget, June 1st is the call, not June 2nd.

M
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just to let you guys know.

M
When you were looking for it—

W
I can do that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
Is there one on May 20th? I can't do May 20th.

W
I don't have it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
May 20th? It may be one of the old ones. It may have been one of the proposed .... So what's our process for—actually, I have it on—

M
I have MU call blocked out but no details, which probably means it was a proposal that was never –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... held up. Who can make it?

M
On the 20th?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
On the 20th.

M
At what time?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... Eastern.

W
I cannot.

W
... do it for an hour and a half.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, so I guess not.

M
Can we do it earlier?

W
Actually, we could do it more than that, 10:00 to noon?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wait, what do you all have?

W
My daughter and son's graduation on that day.

M
I do too.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... early in the morning.

M

I could do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Judy, is that available?

Judy Sparrow – Office of the National Coordinator – Executive Director
Sure, what time, 9:00?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wait, do you mean if it's 9:00 it wouldn't work for you guys?

M
How about 8:00?

(Parties speaking simultaneously)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So any further ... before we open it to public comment?

W
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, let's open it to public comment ....

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you please give the dial-in for the public comment? A reminder it's a three minute time limit. Thank you.

Operator
Our first comment is from Robin Raiford.

Robin Raiford – Allscripts – Executive Director, Federal Affairs
This is Robin Raiford from Allscripts. I just have an additional comment about what was discussed earlier about the smoking status and what that was, and there was a suggestion on some of the measures perhaps to change the name of some of the things so it's more clear what you're looking for. And a comment about the standard for the smoking status is buried in the final rule and I'll send this to Judy Sparrow to send out to the committee on page 44344. There is a standard name for six choices only for smoking status, which is National Health Interview Survey responses which have the recodes associated with them and certainly people that have done certification are familiar with that because that's the only thing that was allowed within the certification process itself.

But under the ONC FAQ where people didn't have to follow the certification workflow or wherever there's great confusion that there's a standard out there in these six terms, that doesn't subsequently flow into the standards list at the end of the final rule. That if the intent is to grow capture of data for National Health Interview Survey with a fixed limit of responses, in this case six, and the other two behavior ones that are out there in the interview survey are activity and for alcohol use. Then it clearly says that's the intent, not this more elaborate capture of tobacco use that are used for the quality measures, because at this point there's great confusion on if you're doing tobacco or you're doing just smoking. And just these six responses, if that could be a consideration to clarify when the options are coming out for stage two. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Robin. We do have a comment in the room.

Lindsay Hoggle – American Dietetic Association – Independent Consultant

My name is Lindsay Hoggle and I'm a consultant to the American Dietetic Association, which is a 71,000 professional member organization of nutrition experts, and what I have to say, I have three points. And thank you for the opportunity to comment and all of your hard work.

I think the value of bringing in ACOs and the Reform Act, along with what we're trying to do and adoption of health IT, we're also trying to change our culture and include prevention and wellness, which unfortunately has not been there a lot recently. And there are three points I wanted to make. One is in reference to food allergies, in stage one due to a lack of standards medication allergies were the only ones that were included, and there's a great deal of loose conversation and even some work done on the Standards and Interoperability framework concerning allergies. The impact is the same to the patient in some of the food allergies in terms of severity, so I'd just ask either that it be put somewhere so that it's not lost and even stage three criteria, like I said, there is a lot of work being done.

The second one is in terms of educational resources, and I'm all for the info button and creating information for patients. I just want to caution on what dieticians and nutritionists have dealt with for as long as I've been in the field, and that is that a lot of patients get instructions from major behavioral changes as they're walking out of the hospital, one time deal. It's the reason that we have the problem that we do is because we can't expect patients to stop smoking, exercise, and change their diet all in one. For that reason I would ask that diet be included in all of the summary of care records, that's just a blanket statement.

And the third part is in terms of downloadable data. I really think there's a real advantage to allowing the patients to receive some of the summary of care records and the referrals, that they can then share with non-physician providers that normally get very little medical information. In terms of outpatient care for nutrition, a lot of times the only thing that we get is a nutrition referral, and we have to stop and back up and get all of the medical history, meds, everything. So thank you for those considerations and I'll look forward to continued.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Lindsay. We have John Travis on the phone.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
Hello. First of all, I wanted to say thank you very much to the committee for taking up, I know my name was mentioned earlier as a source of at last part of an e-mail behind the discussion, so thank you for hearing the concern and I look forward to seeing where it goes. I must admit my head's swimming a little with what was discussed today, but a couple of observations.

One is that at current course and speed certification, as Steve had mentioned, is good through 2011-2012. So if there's any changing criteria that begets a development gap for vendors as a whole, maybe it's not a whole upgrade but we've still got pretty short strokes to respond to anything. Especially as things emerge in the standards nomination process for security and privacy and for interoperability, that's where most of the development gaps are probably going to come from for certain vendors. So just remain sensitive to that, that whatever you do to change certification in 2013-2014, whatever that may wind up being, we're still going to introduce change on the vendors and we're still going to put a process in place that requires a software update.

The other thing I'd encourage, and I respect the point about not wanting to distill or lose the momentum at the outset by creating too much of a delay, I think you also want to balance in not losing people along the way. So if we stay too draconian or too literal with the requirement as it may be right now, you're going to run the risk of dropout in terms of participation potentially both from vendors and providers in those... of meaningful use. And they'll take their lumps with the penalty eventually, potentially anyway, or just say we'll make that our objective to avoid the penalties in the end. I wanted to make sure I was understanding and I think this is how it currently stands that if there's no change then the industry is going to have to have their client bases upgraded to whatever is a 2013-2014 certified system by the start of either federal fiscal year or calendar year 2013. If that's not true that probably could stand some strong clarification in the industry, but that's what we're getting a lot of questions about right now, which certainly

is what compelled my question to begin with. Thank you for hearing that. I'll be following the discussions and seeing where things go and look for opportunities for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Travis. I think we have Allison Viola on the phone.

Allison Viola – AHIMA – Director of Federal Regulations
Good afternoon, Allison Viola from AHIMA. Thanks for the opportunity to comment. I wanted to just go back to some earlier discussion before lunch, late morning, for the section of engaged patients and families and their care, where there was discussion around accessing your health information and ability to download it. I would just encourage you to consider using some consistency in the wording. For example, there are two, I guess you could say measures that offer the ability and there are some others that just allow the provider to have the ability for the patients to view and download. So I would just suggest using some consistency in offering the patient the ability to view and download their information. Thank you for your time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Allison. We have Mark Segal.

Mark Segal – GE Healthcare – Director Government & Industry Affairs
Good afternoon. Thank you. This is Mark Segal with GE Healthcare. First, thank you for a great discussion today on both the objectives and on the timing. On the timing, I think that the number one need that the industry needs is for the Policy Committee to acknowledge the timing problem, which I think you are, the untenable situation between a July 2012 final rule certification criteria and FAQs and clarifications to follow and October or January starts. I think a scorecard is a really good approach, but ultimately I favor that you come out with a definitive recommendation based on that analysis, but with identification of the other options you've considered. I think the industry's really looking for this, particularly those considering attestation this year.

Secondly, some of the issues that have been framed as vendor issues are really ultimately provider issues in terms of quality, safety, and our ability to make other changes that our customers are seeking. Also, I think this was touched on by Judy Murphy and others, beyond the meaningful use measures the quality measures can be really huge in terms of the functionality that's required, particularly in terms of additional data elements and workflow changes.

Then finally on the issue of ACOs and being able to support various delivery system reforms, I think that's a point that's very important. But I'd also emphasize and urge you not to assume that vendors will not be able to support ACOs and similar changes without specific meaningful use and certification changes. The ACO rule as written is really non-prescriptive in terms of specific HIT requirements, certification and things of that sort, and is really focused much more on outcomes in areas of focus, such as care coordination. I can assure you that vendors will be responding and really are responding now to what our ACO customers are needing, regardless of exactly where meaningful use and certification are. So thank you very much for your time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Segal. And the last caller we have Donald May.

Don May – American Hospital Association – Vice President
Thanks. Don May with the American Hospital Association. I really appreciate the opportunity to comment on the conversation you've had here today. I just wanted to make a couple of comments, particularly on the timeline and some of the other things going on. I think it's important to note that you've referenced ICD-10, we've started hearing lots of concerns about the cost of ICD-10, the transition of ICD-10, and while it's important doing that at the same time as changing and upgrading to a stage two meaningful use is something we're getting lots of red flags raised about. It is very, very important to move to ICD-10. We've needed to do it for many years. It's complex enough that CMS, I believe, gave a four year transition to get there, four year planning to get there, so I think it's important to know that that has to take

priority for our IT development over the next couple of years and the resources that that takes both in time, financial and in people is going to be significant. I think that changes to meaningful use and moving to stage two has got to take a second seat to that, which has been a national priority for many, many years and I don't think it makes sense to implement new stage two requirements that then would need to be changed to modify the technology for ICD-10.

The second thing I wanted to talk about real quickly is, is this link with ACOs and other delivery reforms that were part of the ACA, which is very important and IC can be a huge implementer for a hospital or a physician group practice trying to coordinate care and improve outcomes. I think the important thing to remember there is that most of those reforms are going to be on a voluntary basis. They're going to be the innovators and leaders, at least initially, and not only are they going to be leaders in the care delivery model, but they're going to be innovators in IT. As the last caller mentioned, having meaningful use defined isn't necessary for those innovators to move forward with those ACOs, medical homes, they're going to be able to do that with or without a stage two meaningful use. In fact, some of the prescription that might come around stage two might actually be inhibiting of that and the innovation that they may do on their own in the interim. I think overall a desire to make this as simple as possible, we heard the ... of complexity a couple of times here, I think that's going to be what we've seen in the implementation of stage one. And the difficulty providers have had meeting those objectives, meeting the certification requirements, understanding the FAQs, the complexity of this program is already challenging for the vast majority of hospitals and eligible professionals and adding to that complexity is something that while you may want to keep momentum, may actually go in the opposite direction. So I'd really encourage you to keep it simple, focus on the transition to ICD-10, and minimize the barriers that could be there because of added complexity. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. May. We certainly appreciate all of the public comments. With that I'll turn it over to George Hripcsak.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Very good. That concludes today and we'll see you on the telephone next week. Thank you.

Public Comment Received During the Meeting

1. If the problem is alert fatigue, then is it reasonable to make the fact of "alerts on or off" available to the public for decision making.

2. Patients have to benefit from MU! Otherwise, what is the point? Healthcare has been too long in making the patients the object of care. This is the chance to make changes in healthcare by incorporating the patient in new ways. Delay administrative, promote the patient

3. Drug-allergy can be used by all without regard to specialty

4. Certification Comment: An EHR upgrade is not an overnight processes. An EH or EP doesn't go to work December 31s, 2012 using a Stage 1 Certified Product and then wake up on January 1, 2013 using the Stage 2 Certified Product. What you really need is a transition period much like the adoption, update, or implementation portion of the Medicaid Program, where the user starts 2013 using the Stage I product but they are making progress toward completing the upgrade to a Stage II Certified Product. The regulations as they are currently written don't really allow that transition process to occur.

5. Upgrading happens every year for every vendor. This is the normal process...

6. Improved Care Coordination

7. To continue this trend toward development of specific documents could be considered unnecessary by recognizing searchable strings are structured data as well if there is a clinical structure (think SOAP) yet they will allow for knowledge management without throttling the creativity

8. Having referrals recorded or transitions recorder is imperative. So that in the future these transitions can include more participants in care. If we hope to have these transitions recorded, this can set the stage for intervention. An example, if a transition is occurring and the patient has to confirm or acknowledge this would help gain consensus and help patient inclusion. Or if an escalation in care a preauthorization can be done. Capturing transitions in care are necessary for future intervention, inclusion and monitored.

9. Bidirectional occurs in every time something is sent. Even if this is only an acknowledgement that the system received it. Today a lab within a hospital communicates with many other systems. What is the use case?

10. Patient specific education materials include the ability for a patient response to the education, e.g. comprehension, preference and compliance be recorded. Additionally, the EHR will support orders from clinician to the patient directly with an expectation of a response. These can be used in an EMR and PHR or using a secure email. Orders are part of the current process.

11. This is a tough one on LIS. If I have a LIS reporting to the EHR it comes in as a HL7 structured data and LOINC may not be necessary. This may require significant work. If the lab is reported outside of the EMR to another entity or to the HIE in LOINC this is very reasonable. This needs to be discussed more. Labs are reported thousands of times daily and it is mature use.

12. If you are asking to count whether or not Advanced Directives are recorded in the system, it does not matter if it is scanned or captured through some other format. It will require some sort of discrete identifier to locate and count the scanned document or to locate where it is entered.

13. Raising the age, would really help to reach the objective. The population would be relevant and the practice doable.

14. Given the average death average of CMS of 87, 65 years may be too young.

15. The hospital EMR may have the adv directive as noted above, however they would not send it and not send their record to the primary care. The primary care doc could have access. If the notion is that adv dir be sent everywhere, perhaps attaching this to the CCD requirements. Moving it everywhere can add to the confusion

16. Advanced directives are more often used in the hospital setting. This would include emergency response attached to the hospital. The EP may not ever act on these.

17. Advanced Directives - Possibly we could take this opportunity to express the concept of patient's kiosks as the portal of last resort. AD's could be assisted or independent and differently billable.

18. The interview would be, do you have an adv dir? If so what does it say? This is recorded along with asking where is it? If actions need to be taken, it can be retrieved at a necessary time.

19. Defining how the directive "exists" in the chart could be important. Is it necessary to scan this into the chart, or note that it exists and the directions noted, or that it is physically in the chart? If physically scanned in, there may be push back. Where are the scanners? Does the EMR support a scan in bound?

20. JCAHO requires 100% smoking status for adults, along with documenting that discussion about quitting and materials provided

21. To prevent the improper use of insurance "sharing" asking questions like language and race helps to further identify that the patient is the correct patient.

22. Another reason that this is collected is to help identify that the person presenting to them is the patient of record. Often this is a way to help be proactive in fraud. (using others insurance)

23. Hospital ADT generally have language, gender, race today. This is because it is relevant to care. Think sickle cell, or MS or other hereditary issues that would be identified by including this.

24. Alerts in Drugs can always be ignored, but it must be documented in the record. That exists today. Reporting may be more difficult, because it is not looked at total doc or total population today

25. This is a very high error arena.